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Perceptions of School Based Mental Health Services by Directors and Supervisors of Student Services

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by

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ABSTRACT

Key stakeholders in schools must be educated about the importance of increasing access to mental health services in schools. School-based mental health services are designed to increase children's competence and help them meet the societal expectations of school success. The present study examined types of mental health services provided to students in school districts throughout Florida; the extent to which those services were provided to children and families; the beliefs of student services directors and supervisors regarding qualifications of school mental health service providers to provide mental health services; and their beliefs about the impact of mental health services on student academic and behavioral outcomes. Participants in this study included 90 student support services administrators (student services directors, supervisors of psychology, social work, and counseling).

Descriptive analyses revealed that the three most commonly provided mental health services were consultation, normative assessment, and authentic assessment. Interestingly, no mental health service providers (school psychologists, school counselors, school social workers) were considered by student services directors and supervisors as qualified to highly qualified to provide intervention services with minimal to no supervision. Results of this study suggest that student services directors and supervisors have significantly different perceptions about the level of qualifications of mental health providers to provide mental health services. Specifically, the type of

credential (teaching only vs. student support) which the director or supervisor held impacted their beliefs about the school psychologists level of qualification to provide mental health services. Finally, directors and supervisors, combined, had significantly different ratings about the types of mental health services which impacted academic and behavioral outcomes. Directors and supervisors ratings of impact of mental health services on academic and behavioral outcomes were moderated by the type of credential held. Implications of such results may be that mental health providers are *only* encouraged to provide those services which they are perceived to be qualified to provide; training programs may need to develop models which promote collaboration and partnership amongst mental health professionals to increase shared skills; and administrators may place an emphasis or de-emphasis on mental health services based on credential and training background.

Chapter One

Introduction

Statement of the Problem

Schools are expected to educate all students (U.S. Dept. of Education, 2001), including a growing population of students whose mental health problems often impede or interfere with their learning. Conditions contributing to student mental health problems—substance abuse, poverty, homelessness, community violence, and physical abuse—are rapidly becoming a part of the "normal" family culture within which many students grow and develop (National Advisory Mental Health Council, 1990). These conditions do not foster an environment in which a child can meet the expected developmental, cognitive, social and emotional demands (Mash & Barkley, 2003). Failure to meet these demands may lead to "adaptational failure", which is the inability to meet the task demands or developmental norms that are a part of the expression of the normal developmental progress (Mash & Barkley, 2003). Typically, developing children who experience adaptational failure often display high rates of maladaptive behaviors (Mash & Barkley, 2003). Schools, however, are expected to provide a wide range of general, special, and alternative education programs to meet the needs of diverse learners, including those with significant mental health problems (U.S. Dept. of Education, 2001).

The Elementary and Secondary Education Act of 2001, No Child Left Behind (U.S. Department of Education, 2001), expects schools to create environments in which all students can succeed. Providing mental health services in the school is a way

that schools can create this type of successful environment. According to the Center for Mental Health in Schools (2002) a school-based mental health "need" is any need or problem, which produces a barrier to learning. Mental health services in schools are those services that seek to remove those barriers to learning (Center for Mental Health in Schools 2002) and thus address the primary concern of the school system, the child's ability to learn. Mental health services in the school are not limited to only counseling, consultation, and other services traditionally affiliated with mental health. These services may also include time management or study skills sessions, which address academic difficulties that impede a student's learning (Center for Mental Health in Schools, 2002). As schools move forward to address the challenge established by the No Child Left Behind Act of 2001 (U.S. Department of Education, 2001), of "success for all", important questions must be asked about how schools choose to define mental health services, who is best qualified to provide these services and which mental health services result in improved academic outcomes.

Mental health issues which adversely affect children's academic performance include: internalizing problems (e.g., depression and anxiety), externalizing problems (e.g., conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder), family issues (e.g., domestic violence, child abuse, and divorce), substance abuse, anger, poor social skills, stress, lack of family and school support and lack of behavioral, emotional and/or academic skills needed for successful school readiness (Florida Department of Education, 2000; Kestenbaum, 2000). Given the many challenges that children face in the school today, how can schools best meet the needs of the

students they serve? What services ought they to provide? Which professionals are qualified to provide these services in school settings?

Legal mandates such as the No Child Left Behind Act of 2001 (U.S. Dept. of Education, 2001) ensures that schools are held accountable for providing students with quality instruction that is delivered by high quality teachers. The No Child Left Behind Act of 2001 (U.S. Dept. of Education, 2001) allows schools to have the flexibility to use resources where they are needed most and this may include the provision of universal preventative mental health services for general education students. The Individuals with Disabilities Education Improvement Act (IDEIA 2004; Pub. L. No. 108–446) ensures that children with disabilities receive a free and appropriate education. It also requires schools to provide mental health services to students in special education when those services are necessary for a student with a disability to profit from his or her educational experience. Finally, in the state of Florida, the Florida legislature in 1972 enacted the Florida Mental Health Act which is now referred to as the "Baker Act" (State of Florida Department of Children and Families Mental Health Program Office., 2002). The Baker Act helps ensure that adults and children, with a severe mental health condition, that has made them dangerous to themselves or others, are provided a reasonable and just process for involuntary commitment into a mental health facility. Its intent was to encourage individuals to seek mental health care through voluntary commitment, but only when they are able to understand their decision and its consequences. It also separates the process of hospitalization from legal competency and seeks to facilitate a person's return to normal community life (State of Florida Department of Children and Families Mental Health Program Office, 2002). The Baker Act provides schools with a formal process for

providing community mental health care to children with severe mental health problems who may harm themselves or others in the schools.

Although legal mandates encourage schools to provide mental health services to the students they serve, addressing the mental health needs of students typically is not a top priority in school settings (Adelman & Taylor, 1998). The irony of this practice is that educators expect children to succeed academically even when they lack the behavioral, emotional or physical skills required for academic success. Furthermore, the mental health needs of children are increasing (Adelman & Taylor, 1998). This escalation requires mental health professionals (e.g., school psychologists, school counselors and school social workers) to identify effective mental health services that promote both academic and social success.

A report from the National Institute of Medicine (National Advisory Mental Health Council, 1990) estimates that 15% to 22% of the nation's 63 million children have mental health problems that are severe enough to warrant further treatment. Unfortunately, 79% of children aged 6-17 years with mental disorders do not receive mental health care (Katoaka, 2002). Evidence provided by the World Health Organization (2005) indicates that by the year 2020, childhood psychiatric disorders will rise by over 50 percent. Childhood psychiatric disorders are expected to become one of the five most common causes of morbidity, mortality, and disability among children (Shaffer et al., 1996). Research suggests that children with mental health issues are much less likely to achieve academic success and have higher rates of school drop out (Adelman & Taylor, 2001). Early withdrawal from school is a loss for both the individual and the community. Adverse, long term outcomes for high school dropouts include, a

reduced potential to be successful contributors to society and increased potential for unemployment, welfare, and other social services (Cohen, 1998). In economic terms, Cohen (1998) estimated that a single high school drop out can cost as much as $243,000–$388,000 in tax-based support over a lifetime.

According to the Center for Disease Control (CDC), the overall rate of suicide among youth has declined slowly since 1992, but remains unacceptably high at 9.5 per 100,000 suicides a year (CDC, 2004). Suicide is the third leading cause of death among young people ages 15 to 24 years. In 2001, 3,971 suicides were reported in this group (CDC, 2004). Homicide also remains a leading cause of death for young people (CDC, 2001). In the United States, 71% of all deaths among persons aged 10-24 years result from only four causes: motor-vehicle crashes, other unintentional injuries, homicide, and suicide (CDC, 2003). Among youth in the United States between the ages of five and 19, there were 16 homicides that occurred at school in the years 1999-2000 and 2,124 homicides away from school during the same period (U.S. Department of Education and Justice, 2003). The National Crime Victimization Survey (Bureau of Justice Statistics, 2004) reported that the average annual rate of violent crime continues to be highest among youth between the ages of 16 and 19 years who were victimized at a rate of 55.6 per 1,000 persons in 2002-2003 (Bureau of Justice Statistics, 2004). All of these alarming statistics indicate a pressing need for mental health services in the schools, particularly for those youth who are underserved in our society.

Low-income minority children are less likely to have access to mental health services than other groups of children (Adelman & Taylor, 1998). When these children do receive services, they are of poorer quality than those received by children of middle

class parents (U.S. Department of Health and Human Services, 1999). Hispanic-American children and teenagers are the least likely of all minority groups to access mental health care, even though Hispanic-American and African-American children have the highest rates of need for mental health services (U.S. Department of Health and Human Services, 1999).

Children from all racial groups that come from impoverished, low-income backgrounds also are not provided with adequate mental health care services (Barnett, 1998). This is unfortunate, because 50% of impoverished children are at risk for mental health problems (Adelman, & Taylor, 1998). Impoverished children are also at heightened risk for poor academic performance due to differences in physical health, the quality of emotional and cognitive stimulation received at home, parenting, and their early childhood education experiences (Barnett, 1998). Academic failure puts these children at risk for experiencing later mental health problems. Unfortunately their mental health needs may go untreated because access to mental health services for low SES families is quite limited (Barnett, 1998).

Schools are the most likely setting in which low SES minority children receive mental health care (Weist, Paskewitz, Warner, & Flaherty, 1996). Children and youth spend a great deal of time in school settings, and schools are one of the few stable institutions that exist in impoverished, rural, and underserved areas (Weist, Paskewitz, Warner, & Flaherty, 1996). Services offered in schools are more accessible, affordable, and less stigmatizing than off-site centers, such as community-based mental health centers. Research has shown that schools reduce barriers to mental health care (e.g.,

transportation, financial problems) that constrain the provision of services to those children that need them the most (Weist, Paskewitz, Warner, & Flaherty, 1996).

When the educational system of the state or district decides to serve as a provider of mental health services, in addition to a provider of educational services, the system must assure that it has the commitment from its individual schools, as well as the financial and personnel resources. School psychologists, school social workers, and school counselors are the primary providers of mental health services in school settings. The recommended school psychologist to student ratio is 1:1500, the recommended school counselor to student ratio is 1:560, and the recommended school social worker to student ratio is 1:2000 (Kestenbaum, 2000; Curtis, Grier, Abshier, Sutton, & Hunley, 2002; Franklin, 2000). When the mental health provider to student ratio exceeds the recommended ratios mentioned above, it becomes challenging for the mental health provider to offer helpful services for students. Providing effective services becomes difficult when mental health providers have caseloads that restrict the amount of time available for serving a student.

Research consistently shows that improvement in the social, emotional, and behavioral well-being of a child is significantly related to higher levels of academic achievement, as well as lower rates of aggression, criminality, and mental health problems (Owens & Murphy, 2004). Universal, school-based intervention programs that teach positive social, emotional, and behavioral skills have been shown to also improve the academic performance and social adjustment (e.g., decline in office referrals and disruptive behaviors) of the students in those school environments (Owens & Murphy, 2004). Finally, there is empirical literature, which supports the relationship between

student mental health development and academic school success. When children are not successful in school then they have failed to adapt to the school environment and are at risk for a variety of mental health problems (Mash & Barkley, 2003).

Willcutt and Pennigton (2000) documented this finding in their investigation, which examined the mental health outcomes of children who read on grade level compared to those who did not read on grade level. These researchers found that children who failed to read on grade level, because of a reading disability, exhibited significantly higher levels of anxiety and depression, as compared to children who read on grade level. Kellam, Rebok, Mayer, Ialongo, and Kalodner (1994) found a similar outcome when the results of their study indicated that failure to master core developmental tasks such as reading in the early primary grade could actually contribute to higher rates of depression among some individuals in schools. These aforementioned findings support the idea that schools are an important environment for producing effective student outcomes and contributing to the reduction of adaptational failure in childhood (Adelman & Taylor, 2001). It is hypothesized that when a child fails to meet his or her expected developmental norms, problems emerge, such as distress or unhappiness, peer rejection, poor academic performance, school dropout or delinquency (Masten & Curtis, 2000). Schools have the ability to help kids to become competent and successfully meet their expected developmental norms of childhood. When children are made competent through the provision of school services, we are able to ameliorate many of the problems in psychopathology that are associated with adaptational failure (Mash & Barkley, 2003).

Rationale

Although studies have been found which examine administrators' beliefs of the roles of mental health service providers and the services they provide (Agresta, J., 2004;

Burnham, J. J., & Jackson, C. M., 2000; Hartshorne, T.S., & Johnson, M.C., 1985; Lockhart, E. J., & Keys, S. G., 1998; Thomas, A., Levinson, E. M., Orf, M. L., & Pinciotti, D., 1992), a literature search found no previous studies which examined administrators' beliefs regarding the relationship between mental health services and who is best *qualifie*d to provide these services.

The beliefs of district and state school administrators, regarding what is important for children's educational success, help to shape the values and mission of the educational system, which are later established by school boards and communities (Leadership Training: Continuing Education for Change, 2003). Thus, it is critical to know the beliefs of student services directors and supervisors of student services regarding mental health services in the school as well as their beliefs about who they believe ought to be the provider for different types of mental health services in schools. Knowledge of these beliefs can provide student services directors and supervisors of student services with opportunities for professional development in areas which will benefit children's mental health.

This study examined the beliefs of student services directors and supervisors of student services about whom they believe ought to be the provider for different types of mental health services in schools. Research has indicated that educators perceive the school psychologist as being involved in mostly assessment-related activities and some counseling, and consultation (Fagan & Wise, 2000). The school counselor is perceived as providing mainly individual and group counseling, guidance programs, helping with school-wide testing and academic scheduling as well as helping school staff with children who have behavior or academic problems (Agresta, 2004). Finally the school social

worker is viewed as a provider of children and families, an informant on children's social histories, and an organizer who is able to bring in community resources (Agresta, 2004). An analysis of the beliefs student services directors and supervisors of student services about mental health services, who is qualified to provide those services and the impact of those services on academic and behavioral outcomes, can help to bridge the gap in goals established by mental health professionals in the school and other personnel in the educational system.

Purpose of Study

The purpose of this study was to determine the types of mental health services provided to students in school districts throughout Florida and to what extent they are provided to children and families. In addition, the purpose of this study was to investigate the perceptions held by student services directors and supervisors about school mental health providers' qualifications to provide mental health services and whether the type of credential held by directors and supervisors moderated these beliefs. Finally, this study examined the perceptions held by student services directors and supervisors about the impact of specified mental health services on student academic and behavioral outcomes and whether the type of credential held by directors and supervisors moderated these beliefs.

Research Questions

The following research questions were addressed in this study:

1. (a) What is the nature and extent of mental health services provided to students by school districts in the state of Florida?

(b) Is there a difference in the profile of mental health services provided by school districts based on district size?

2. To what extent do student services directors' beliefs about the qualifications of student services personnel to provide mental health services differ from those of student services supervisors (i.e., supervisor of psychological services, supervisor of guidance and counseling services, and supervisor of social work services)?
3. To what extent does the credential held by student services directors and supervisors moderate their beliefs about qualifications of individual student services providers to provide mental health services to students and their families?
4. To what extent do student services directors and supervisors differ in their perceptions of the perceived impact of specified mental health services (e.g., counseling, consultation, interventions) on students' academic and behavioral outcomes?
5. To what extent does the type of credential held by student services directors and supervisors moderate their beliefs regarding the impact of mental health services on academic and behavioral outcomes of students?

Significance of Study

It was anticipated that findings from this study would make a significant contribution to the field of school psychology, education, and to the school mental health service delivery system in several ways. First, this study can provide information for pre-service training programs for mental health professionals, with information about how student services directors and supervisors of student services view mental health services in the schools. Second, this study can offer information to national and state professional

associations about the types of mental health services that need to be addressed with regard to training, research, and professional practice. Third, this study may provide the district and the state personnel information regarding whether a director's prioritization of mental health services is driven by tradition or whether it is closely tied to the mission of the district. Finally, this study can assist in policy development, that supports efforts, which assist in increasing academic competency (e.g., curriculum based measurement and DIBELS), to be seen as a part of the mental health service delivery in school settings.

Definition of Terms

Mental Health. Mental health issues embody those characteristics and factors, which closely relate to mental well-being. The lack of mental well-being is characterized by an inability to adapt to one's environment and regulate behavior (Webster's, 2002). Mental health issues that adversely affect children's academic performance include: internalizing problems (e.g., depression and anxiety), externalizing problems (e.g., conduct disorder, oppositional defiant disorder, and attention deficit hyperactivity disorder), family issues (e.g., domestic violence, child abuse, and divorce), substance abuse, anger, poor social skills, and stress (Florida Department of Education, 2003; Kestsenbaum, 2000).

Services that are considered to be Mental Health Related (Luis, Curtis, & Powell 2005):

Individual therapy/counseling	Crisis intervention
Family therapy/counseling	Prescribing medication/Medication management
Group therapy/counseling	Designing/administering individual service plans
Substance abuse counseling	Program development and administration
Early intervention services	Personnel training
Family/Child advocacy	Research and evaluation
Behavior management consultation	

Supervisors of Student Services. These individuals are the supervisors housed under the department of student services (psychology, social work, and counseling). The student services staff helps to facilitate the development of critical support services programs so that observable and measurable indicators of success for students are achieved (Florida Department of Education, 2003).

Administrators. These individuals are also known as Directors of Student Services and they supervise the Supervisors of Student Services (psychology, social work, and counseling).

Chapter Two

Literature Review

Introduction

The purpose of this chapter is to review the existing research literature that explores the types of mental health services provided in schools and the relationship of those services to student outcomes. First, a review of the literature regarding the definition of mental health services will be presented. Next, the history of child mental health services will be examined. The relationship between mental health and student outcomes will then be introduced. An examination of effective mental health services in the schools will be presented. Finally, the role of the school psychologist, school counselor, and school social worker in mental health service delivery in the school will be examined.

Defining Mental Health Services

The Center for Mental Health in Schools (2002) states that a school-based mental health "need" is any need or problem, which produces a barrier to learning. Mental health services in schools are those services that seek to remove those barriers to learning (Center for Mental Health in Schools 2002). Traditional mental health services include counseling, consultation, psychological skills training and crisis intervention. However, if mental health "needs" are defined as any need that is a barrier to learning, then a broader view of mental health services might include problem solving, tutoring, academic interventions or study skills sessions, provided to improve a child's academic competence. Clearly, defining mental health services is difficult when such a broad definition of mental health "need" is posited. The Policy Leadership Cadre for Mental

Health in Schools (2001) has recognized this difficulty and stated, "...even with a dictionary-type definition, individual interpretations would likely generate a hodge-podge of approaches" (p.3).

A number of professional associations have provided policy statements addressing mental health services in schools. In a position statement titled, "Mental Health Services in the Schools", the National Association of School Psychologists (NASP) provided its perspective on mental health service delivery in schools:

> The National Association of School Psychologists recognizes that school success is facilitated by factors in students' lives such as psychological health, supportive social relationships, positive health behaviors, and schools free of violence and drugs. Mental or psychological health in childhood and adolescence is defined by the achievement of expected developmental cognitive, social, and emotional milestones. Mental health is evidenced by the students' forming secure attachments, developing satisfying social relationships, and demonstrating effective coping skills. Mentally healthy children and adolescents enjoy a positive quality of life; function well at home, in school, and in their communities; and are free of disabling symptoms of psychopathology (NASP, 2003, p.1).

Although this position statement provides a conceptual overview of what defines mental health in children and adolescents, it does not state specifically what services should be provided. However, this position statement advocates for the inclusion of effective, comprehensive mental health services in the schools, emphasizing prevention and early intervention. A number of national health and mental health organizations (U.S. Department of Health and Human Services (HHS), 1999: Center for Mental Health

in Schools, 2002) have stated that mental health services must be included in school reform efforts in order to help students overcome barriers to learning, which may result from poverty, difficulties in the family, and/or social and emotional needs. The HHS position recognized that school systems are not responsible for meeting every need of their students, but when those needs adversely impact learning, schools must then make every attempt to meet those needs in order to facilitate academic progress (U.S. Department of Health and Human Services (HHS), 1999).

Health and human service provider organizations are not the only professional groups to recognize the relationship of mental health needs and school performance. The National School Board Association (1991) emphasized the important relationship of collaborative services of mental health and its outcomes on learning:

> Children's learning directly benefits from adequate social services and suffers when such services are not forthcoming. If the schools are to be held accountable for students' academic achievement and preparation for the workplace, they have to have a vested interest in other factors that impact learning. (p.16)

Although no agreed upon definition of school-based mental health services exists, there is agreement that students have mental health needs that interfere with school performance, that schools must address those needs and that a cadre of strategies and delivery systems exist to accomplish that goal.

The Historical Background of Child Mental Health

The United States, similar to the Western European nations, developed child-focused services to address what they considered to be child mental health needs, during the latter half of the 19th century and the beginning of the 20th century (Pumariega &

Vance, 1999). The combination of compulsory school attendance in the 1860's, the large numbers of immigrant children in the country and poor child health and hygiene led to increased pressure on schools to provide children with psychological services (Hoagwood & Erwin, 1997, p.436). The establishment of child abuse laws in the 1880's and juvenile courts in the 1890's helped policy leaders to recognize the existing child mental health services which previously had been in place in society, were no longer adequate to address the needs of the complex and growing children's population of the United States (Pumariega & Vance, 1999).

Counseling school-aged children who were juvenile offenders in juvenile court clinics was one of the earliest child mental health services. Prior to this, juveniles were imprisoned with adult offenders without any counseling services provided to them (Pumariega & Vance, 1999). The first mental health clinic for children with a focus on school problems was founded in 1896 at the University of Pennsylvania (Pumariega & Vance, 1999). Soon after, in 1898, the Chicago school board surveyed their children to determine the population's mental and physical characteristics. In response to the survey, the school board gave authorization for the development of a "psycho-physical laboratory" to be open on Saturdays. By 1914, about 20 such school-based clinics were thought to be in existence in the United States (Hoagwood & Erwin, 1997).

In 1922, the Commonwealth Foundation conducted a study that recommended and funded the development of child guidance clinics throughout the United States of America. The clinics were initially staffed by social workers but soon attracted a wide variety of professionals, ranging from pediatricians to psychologists (Pumariega & Vance, 1999). In 1930, the Pennsylvania State Department of Education developed the

model for certification of school psychologists, whose primary purpose was to designate pupils as candidates for special education. In 1975 with the congressional passing of the Education for All Handicapped Children Act (Education for All Handicapped Children Act; P.L. No. 94-142), students with disabilities were entitled to a free, appropriate public education. Under the subsumed special education services, related services (e.g., psychological services) were to be provided by the school district. These related services ranged from consultation and individual, group or family counseling to speech/language therapy, physical and occupational therapy (Hoagwood & Erwin, 1999). In the 1970's, the related services being provided to students with disabilities began to be viewed more broadly (outside of PL 94-142) to include general education students (Hoagwood & Erwin, 1999).

Historically, both the educational system and the community have made attempts to meet the mental health needs of the students. However, as the mental health needs of student and families have grown and become more complex, existing models of mental health service delivery have remained the same. As a result, the mental health needs of children and youth increasingly have been unmet (Hoagwood & Erwin, 1999).

Lack of Mental Health Services for Children

As a nation, we are in amidst of a public crisis in caring for our children and their emotional, behavioral, and psychological needs. The U.S. Department of Health and Human Services (HHS) (1999) report that 1 out of every 5 children has a diagnosable mental, emotional, or behavioral disorder and 1 in 10 children suffer from a serious emotional disturbance. However, 79% of children aged 6-17 with mental disorders do not receive mental health care (Katoaka, 2002). It is reported, "The majority of children with

mental health problems fail to receive appropriate treatment. Many of the six to eight million children in our nation who are in need of mental health interventions receive no care. For the children that receive services, perhaps 50 percent of those in need of treatment receive care that is inappropriate for their situation" (Flaherty, Weist & Warner, 1996, p. 342).

HHS (1999) also reported that minority children are less likely to have access to mental health services than other groups of children. If they receive services, they are often of poorer quality. Hispanic-American children and teenagers are the least likely of all minority groups to access mental health care, even though it is reported that Hispanic-American and African-American children have the highest need (U.S. Department of Health and Human Services, 1999). Children from all racial groups that come from impoverished, low income backgrounds are often not provided with adequate mental health care services, even though 50% of impoverished children are at risk for mental health problems (Adelman, & Taylor, 1998).

For children that have mental health needs, schools can serve as the ideal location for the provision of mental health services. All children, youth, and families have access to school settings, regardless of socioeconomic status. Providing mental health services in the schools eliminates many of the barriers (e.g., accessibility, acceptability and funding), which keep children from receiving mental health services (Ambruster, Gerstein, & Fallon, 1997). Ambruster, Gerstein, and Fallon (1997) suggest that the negative stigma of receiving mental health services in communities decreases when services are offered at a school versus a clinic setting. Finally, many of the school mental health clinics accept Medicaid for eligible children and services such as counseling and social skills training

can be provided free to the child (Ambruster, Gerstein, & Fallon, 1997). Schools have been shown as the most optimal place for developing psychological competence and teaching children to make informed and appropriate choices concerning their health, education and many other aspects of their lives (NASP, 2003).

Mental Health and Student Outcomes

There has been a demonstrated relationship between early academic difficulties and mental health outcomes (Stipek, 2001; Good, Simmons, & Smith, 1998). The U.S. Surgeon General's report (U.S. Department of Health & Human Services, 1999) has also linked educational performance to mental health. The U.S. Surgeon General (1999) notes that mental health is a critical component of children's learning and general health and that fostering social and emotional health in children as a part of healthy child development must be a national priority (U.S. Department of Health & Human Services, 1999). The report also stated its commitment to "…integrating family, child, and youth-centered mental health services into all systems that serve youth" (U.S. Department of Health & Human Services, 1999, p. 124). One of these systems is the school, which is the sole, but presently inadequate, source of mental health service delivery for a number of students (Burns et al, 1995).

A legal mandate that has encouraged school mental health service delivery, is the Education for All Handicapped Children Act of 1975 (Education for All Handicapped Children Act; P.L. No. 94-142) which is presently known as Individuals with Disabilities Education Improvement Act of 2004 (IDEIA 2004; Pub. L. No. 108–446). This legal mandate states that school districts must not only provide a free and appropriate educational program to all handicapped children in the most least restrictive environment

but that school districts should provide related services (e.g., counseling) to students who exhibit emotional or behavioral disorders and need the services to benefit from their education. This law has helped to strengthen the obligation of schools to provide appropriate educational services to children with emotional problems, leading to an expansion of mental health services in the schools (Flaherty, Weist, & Warner, 1996).

One way that schools can address the obligations of school mental health service delivery is by making children competent and fostering resilience within them. If a child is made competent in the tasks of childhood that they are expected to master, then many of the mental health problems that may arise later in life due to feelings of incompetence are ameliorated. Many of the behavioral and emotional problems experienced in children's psychopathology are a result of adaptational failure. According to Mash & Barkley (2003), adaptational failure involves the exaggeration or diminishment of normal developmental expressions, interference in normal developmental progress, and failure to master developmental tasks, and/or use of non-normative skills as a way of adapting to regulatory problems or traumatic experiences. When children fail to adapt and develop a sense of competency by meeting the expectations in school or society they often have elevated rates of maladaptive behaviors.

Student performance and mental health. Research studies have shown that students experiencing academic and behavioral failure often have internal and external stressors (Policy for Leadership Cadre for Mental Health in Schools, 2001). Examples of such outcomes were documented in an empirical investigation by Willcutt & Pennigton (2000), which found that children who failed to read at grade level, because of a reading disability, exhibited significantly higher levels of anxiety and depression, as compared to

children who read on grade level. Another study by Tremblay et al. (1992) investigated the relationship between student academic performance and conduct behavior problems. Tremblay et al. (1992) found that children who had experienced early academic failure were at a much higher risk for problems with delinquency regardless of whether the youth displayed disruptive behavior disorders. Petras, Schaeffer, Ialongo, et al. (2004) had similar findings in their study which investigated reading achievement and criminal behavior. The results from this study showed that students who were on a pathway towards increasing aggression and had high reading achievement in the first grade were less likely to exhibit criminal behaviors and have a criminal arrest than those with low levels of reading achievement and increasing aggressive behaviors.

Research has also shown that increasing a child's level of academic competency can significantly decrease their levels of maladaptive behaviors. Scott & Shearer-Lingo, (2002) investigated whether increasing the reading achievement of students in a self-contained EBD classroom would simultaneously increase the student's behavior. The results of this study indicated that facilitating reading fluency in self-contained classrooms for students with serious emotional and behavioral disorders had positive effects on both their reading achievement and on-task behavior. In a study by Ginnsburg-Block and Fantuzzo, (1998) they found that when low achieving and performing third and fourth grade students were taught mathematics problem solving skills (e.g., strategies for solving problems and using manipulatives for math problems) and reciprocal peer tutoring was implemented, their academic motivation along with their levels of social competence was increased.

Mental health on student performance. School mental health services have also been shown to affect individual student-level outcomes (e.g., grades, retention, attendance, graduation) and system-level outcomes (e.g., reduction of inappropriate special education referrals, suspension/expulsion rates) (Bruns, Walrath, Glass-Siegel, & Weist, 2004). In an era of school accountability, school leaders often encourage services, which assist in the reduction of barriers to learning, in order to advance positive educational outcomes. The provision of mental health services in schools has been shown to decrease the rate of special education referrals for children suspected of having emotional or behavioral difficulties.

Bruns, Walrath, Glass-Siegel, & Weist (2004), found that classroom teachers in expanded school mental health service schools were less likely to refer a student for special education because of emotional and behavioral difficulties than when they were in a school that did not provide comprehensive mental health services. When mental health services were implemented in the Baltimore city schools, the researchers found that teachers were more likely to refer a child with suspected emotional or behavioral difficulties to a mental health professional employed at the school rather than refer them to a special education problem solving team.

Mental health services in schools have also been found to have a positive impact on the rate at which students are suspended from school (Atkins, et. al, 2002). While suspension is used as a mechanism to maintain a safe school environment, suspensions are usually a result of aggregated minor offenses, which do not involve dangerous harm to any of the parties involved (Bruns, Moore, Stephan, Pruitt, & Weist, 2005). In fact, research has documented that suspension can make behavior problems worse because

students may prefer to be out of school and therefore exhibit behaviors that ensure suspension (Atkins, et. al, 2002). Unfortunately, schools often suspend the students who are in greatest academic, emotional, and economic need. Rather than finding services which promote the behavior change that these students need, suspension often places them in unsafe settings or settings which are restrictive and do not address their mental health needs (Atkins, et. al, 2002). Bruns, et. al. (2005) found that just having the presence of clinical staff from community agencies in a school does not decrease the overall suspension rates of students. However, providing school-based clinical mental health services alongside systematic interventions for behavior problems helped to reduce the rate of suspensions in schools. Such reductions could be achieved by using targeted and well-implemented interventions such as classroom behavior management, social skills training, providing alternatives to suspension, and individual and group prevention programs for students at risk for suspension (Bruns, et. al., 2005)

Importance of Mental Health Services in Schools

There is an ongoing debate as to whether schools should have to meet *all* of the mental health needs of children. According to the Policy Leadership Cadre for Mental Health in Schools (2001), the school's focus is education, not mental health and with accountability and reform that targets instructional outcomes. The results of the studies by Scott & Shearer-Lingo, 2002; Ginnsburg-Block and Fantuzzo (1998); Tremblay et al., (1992); Petras, Schaeffer, Ialongo, et al. (2004) suggest that increasing academic competencies increases mental health outcomes and the studies by Bruns, Moore, Stephan, Pruitt, & Weist, 2005; Bruns, Walrath, Glass-Siegel, & Weist, 2004 suggest that increasing students' mental health has a positive impact on student outcomes. These

results suggest that schools should be concerned about providing mental health services in the school because the outcomes of school mental health service delivery are linked to the mission of education, which is increased academic competency.

The Leadership Training: Continuing Education for Change (2003) states that school personnel and community members must view effective mental health services in schools differently. According to the Policy Leadership Cadre for Mental Health in Schools, (2001) effective mental health services are not just about diagnosing students with problems, providing therapy and behavior change, connecting community mental health providers with schools or even just about empirically supported treatments. Rather, effective mental health services encompass other services such as, programs which promote social-emotional development, increase competence, prevent mental health problems, enhance resilience and increase protective buffers (Policy Leadership Cadre for Mental Health in Schools, 2001). It is recommended these services be provided as early as possible before the onset of severe learning, behavioral, or emotional problems as services which are effective help school staff address barriers to learning and promote healthy development. Early intervention is successful, in that it addresses mild psychosocial problems quickly and thereby prevents unnecessary entry into special education (Foster, Rollefson, Doksum, Noonan, & Robinson, 2005). Addressing psychosocial problems early will allow students to be successful in the classroom and decrease or eliminate the occurrence of secondary problems related to mental health such as learning, attention, and attendance problems and the rate of student drop-outs (Leadership Training: Continuing Education for Change, 2003).

Early intervention services, such as anger management, conflict resolution, positive behavioral support, communication skills, and character education are universal prevention services, which are expected to meet the needs of the majority of the school population. These universal prevention services use the available resources of the school to promote a learning environment in which the teacher is able to effectively teach and the students are able to effectively learn. An environment that provides effective mental health services is characterized by a climate of mutual caring and respect, acceptance of responsibility, clear expectations, and high personal and academic standards paired with essential resources and supports (Leadership Training: Continuing Education for Change, 2003). The secondary level of effective mental health services addresses individual differences in motivation and development of each particular student, so that students can succeed in the positive environment, which has been established for them. The more a school provides a comprehensive range of services and interventions, the more likely the learning, emotional and behavioral problems will be prevented or identified early after the onset. For those more serious problems, which impede learning, the students will receive intensive, corrective interventions (Leadership Training: Continuing Education for Change, 2003). The emotional and academic success of our children in school depends on this type of effective mental health service delivery.

Role of School Psychologist, Counselor and Social Worker and Mental Health in Schools

It is critical for the implementation of effective mental health services, that mental health practitioners are confronted about the current fragmentation of services, which marginalize mental health services in schools. There is a need for collaboration and professional teamwork among the three mental health professional groups that are housed

under the student support services: school psychologists, school counselors, and school social workers (Center for Mental Health in Schools, 2002). The role of each school-based mental health practitioner will be examined separately and connected to their current role as a provider of mental health services in the school.

School Psychologist. With the development of The Education for All Handicapped Children Act in 1975 (Education for All Handicapped Children Act; P.L. No. 94-142), the provision of psychological services became mandatory in the schools (Thomas, Levinson, Orf, & Pinciotti, 1992). These services have typically been provided in most schools by school psychologists (Thomas, Levinson, Orf, & Pinciotti, 1992). Early history has depicted the school psychologist's role as primarily assessment. The first psychologist, Arnold Gesell, was appointed with the title of school psychologist and hired in 1919 by a Connecticut school to assess children with need (Pumariega & Vance, 1999). After the enactment of P.L. No. 94-142, in 1975 school psychologists became more closely identified with testing and special education placements (Fagan & Wise, 2000).

The role of the school psychologist has been redefined and expanded over the past 20 years. This role expansion includes consultation, counseling and behavior modifications, and research and evaluation (Nastasi, Varjas, Bernstein, & Pluymert, 1998). Despite the opportunities for role expansion, Fagan and Wise (2000) report that assessment-related duties still occupy a large portion of the school psychologist's time. A study conducted by Curtis, Grier, Abshier, Sutton, and Hunley (2002) revealed that, school psychologists spend approximately 41% of their time in assessment, 25% in report writing, 25% in meetings, and 8% in other activities.

The National Association of School Psychologists (NASP) establishes standards for credentialing and training in school psychology. According to NASP the current roles of a school psychologist include: (a) assessment, (b) consultation, (c) prevention, (d) education, (e) health care provision, (f) research and planning, and (g) intervention. Intervention includes mental health services such as social skills training, crisis intervention, mediation, counseling, and consultation (NASP, 2003).

School psychologists can assume key roles in the development, implementation, and evaluation of school-based mental health programs (Nastasi, Varjas, Bernstein, & Pluymert, 1998). Nastasi, et al (1998) identified seven key roles that the school psychologist can assume in delivering mental health services in schools. These key roles are:

> "… (i) prevention specialists who help teachers and school administrators foster the development of competent (mentally healthy) individuals. (ii) Child advocates who assist schools in establishing mechanisms for identifying and treating students with psychiatric disorders. (ii) Direct service providers to help children with emotional disorders such as depression and to families who have preschoolers that are at risk or have disabilities. (iv) Trainers of teacher consultants that will extend the scope of consultation services in schools. (v) Health care service providers; (vi) system-level interventionists, and (vii) organizational facilitators in school reform and interagency collaboration." (p. 217-218).

Clearly, school psychologists can provide mental health services in addition to traditional assessment. Studies have investigated administrators' views on the role of

school psychologists in providing mental health services. In a study conducted by Cheramine and Sutter (1993), 80 special education directors evaluated the role of the school psychologist, the effectiveness of mental health service delivery by school psychologists and the job activities in which school psychologists were expected to be involved. The results of the study revealed that consultation was the most common function of school psychologists. The mental health services that they believed school psychologist commonly provided were assessment, consultation, and handling crises. However, the directors believed that school psychologists should become more involved in the areas of counseling and consultation services.

In another study by Gilman and Gabriel (2004), 1,710 teachers, school psychologists and administrators were surveyed about the school psychologist's role as a mental health professional. The results of the study revealed that more teachers, school psychologists, and administrators desired school psychologists to be more involved in individual counseling, group counseling, and crisis intervention. They also desired that school psychologists have an increased involvement with regular education students, parent consultation and parent workshops. However, although teachers and administrators "desired" more involvement in these different areas of mental health service delivery, they still "expected" that the school psychologist would primarily be involved in assessment-related activities (Gilman & Gabriel, 2004). It is also notable that the results of this study revealed that teachers perceived the role of the school psychologist as less helpful to students than administrators (Gilman & Gabriel, 2004). This could be a result of teachers desiring school psychologists to be involved in more activities like consultation and counseling yet expecting that the school psychologist's

role is to actually provide more traditional assessment services. These perceptions of the school psychologist, as an expert of assessment, could serve as barriers to the school psychologist's role as a mental health provider. School psychologists will have to sell their skills as mental health professionals and help teachers become aware of the types of mental health services they are able to provide that will help students meet their educational needs for success in school.

School Counselor. School counselors are assumed to be the experts in the roles of psychological adjustment and personal problems (Agresta, 2004). Though services vary by school and by region, school counselors typically provide individual and group counseling, guidance programs, help with school-wide testing and academic scheduling, as well as help school staff with children who have behavior or academic problems (Agresta, 2004).

According to the American School Counselors Association (ASCA), the focus of school counseling is to promote student learning through an interconnection of student development. The areas of student development are: (a) academic, (b) career, and (c) personal/social (ASCA, 2003). The definition of the current role of school counseling is as follows:

"Counseling is a process of helping people by assisting them in making decisions and changing behavior. School counselors work with all students, school staff, families, and members of the community as an integral part of the education program. School counselors promote school success by focusing on academic achievement, prevention, and intervention activities, advocacy, and social/emotional and career development" (Campbell & Dahir, 1997, p.8).

Burnham & Jackson (2000) cite (a) individual counseling, (b) small group counseling, (c) classroom guidance, and (d) consultation as the primary roles of the school counselor. However, as demographics change and the needs of students evolve, school counselors may have to determine whether the services they offer meet all of the needs of the students in their schools.

In a study by Agresta (2004) counselors reported spending at least 19 percent of their time in only one role, individual counseling. Counselors reported they would like to spend even more time in individual (26.2 %) and group (13.7 %) counseling. Finally, counselors reported that they would like to spend more time in parent education and consultation activities than they currently spend. This study suggested that although, school counselors are providing counseling as a mental health service, they would like to become even more involved in this activity and also provide more consultation and parent training services which will benefit children in schools.

Fitch, Newby, Ballestero, & Marshall (2001) conducted an investigation of future school administrators' perceptions of the professional role of school counselors. The researchers believed the investigation was important because the administrator of the school in which school counselors are housed often determines the professional role of school counselors. Studies have found that administrators and school counselors may often disagree on the school counselor's role and this source of disagreement may be a cause of frustration for the school counselor and may serve as a barrier to the school counselor in the provision of mental health service delivery (Fitch, Newby, Ballestero, & Marshall, 2001). The results of the study indicated that future school administrators rated crisis response, providing a safe environment, communicating with students, and helping

students with transitions as important tasks to be performed by the school counselor. Future administrators also indicated that they believed the school counselor should be involved in discipline actions, record keeping, assisting with special education services, and testing of students (Fitch, Newby, Ballestero, & Marshall, 2001). The results of this study are important because school counselors often perform duties that are unrelated to the role as defined by ASCA. As a consequence many students do not receive individual and group counseling or the guidance they need to remove classroom barriers to learning (Fitch, Newby, Ballestero, & Marshall, 2001).

School Social Worker. The profession of School social work began to emerge at the beginning of the 20th century. The school social worker was known as the "visiting teacher" because he or she was responsible for ensuring that children attended school and helping children acclimate and adjust in school (Agresta, 2004). It was not until the 1940's and 1950's that the term "visiting teacher" was replaced with the title of "school social worker".

The role of the school social workers became more defined as a result of PL 94-142. School social workers were now expected to complete social histories, counsel children and families, organize and bring in community resources and work with all of the ecological variables connected to the child in order to promote student adjustment (Agresta, 2004). In a survey by Agresta (2004), school social workers reported that they spent the majority of their time providing individual counseling, group counseling, and conflict intervention and crisis resolution.

The School Social Work Association of America (SSWAA) mission statement states that the role of the school social worker is:

> The role of the school social worker is specialized area of practice within the broad field of the social work profession. School social workers bring unique knowledge and skills to the school system and the student services team. School social workers are instrumental in furthering the purpose of the schools, to provide a setting for teaching, learning, and for the attainment of competence and confidence. School social workers are hired by school districts to enhance the district's ability to meet its academic mission, especially where home, school and community collaboration is the key to achieving that mission (SSWAA, 2006, ¶ 1).

Agresta (2004) investigated school social workers' perceptions of their expected and desired roles in the provision of mental health services. The average school social worker reported spending about 17 percent of time on individual counseling, 10 percent of time in group counseling and about 11 percent of time in administrator and teacher consultation. Most social workers indicated that they desire to spend more time on individual and group counseling and they would like to dedicate less time to consultation. Another result from the study conducted by Agresta (2004) was that community outreach, an area that is more commonly identified with social work, was not viewed by social workers as taking up much of their professional time.

Similar to the other mental health professionals, one of the major issues facing school social workers is the reconceptualization and reinvention of the role of the school social worker. The role of the school social worker now includes prevention specialist, crisis manager, assessment specialist, referral agent, and case manager. School social workers may also find themselves responsible for carrying out interventions for children

in the schools. As the role changes for school social workers and it becomes more defined, school social workers may need to collaborate even more with other school staff and school mental health professionals, in order to promote healthy development, which enhances school success (Franklin, 2000).

Summary

Schools are expected to educate students whose social-emotional problems significantly interfere with the learning process in the school (Adelman & Taylor, 2000). Many schools and legislators believe that it is not the responsibility of the school to provide extensive mental health services, but that it is only their job to "educate" (Policy Leadership Cadre for Mental Health in Schools, 2001). However, research has shown the provision of mental health services in the schools, are essential to achieve positive educational outcomes (Adelman & Taylor, 2000). Currently, in many schools there is a fragmentation of services amongst the different mental health service providers (Adelman & Taylor, 2000). There is also a misperception of the expected roles of mental health providers. This misperception of expected versus desired roles serves as a barrier in mental health service delivery to children. In order to provide comprehensive, multifaceted and cohesive services which overcome the barriers of learning, professionals must not only redefine their roles and help school personnel understand their roles, but they must also collaborate with one another to meet their current population of students.

Effective mental health services examine systemic issues, which impact healthy development, and they increase the school academic climate (Leadership Training: Continuing Education for Change, 2003). Effective mental health services support students, families, and staff and rely on evidence-based practices which promote learning,

which is found to be connected to healthy social-emotional development (Leadership Training: Continuing Education for Change, 2003). The development of No Child Left Behind Act of 2001 (U.S. Dept. of Education, 2001), with recommendation for expanding school-based mental health services to remove barriers to learning creates a need to assess attitudes and current practices of mental health services provided in schools. This act also provides the opportunity for school psychologists, school counselors, and school social workers to redefine and expand their roles from what have been their previous roles in the schools. All three groups of mental health professionals have the ability to move beyond what has been known to be their more traditional roles in the schools. These roles have typically not addressed all of the growing mental health needs and demands of their changing student population.

Chapter Three

Method

The study examined the types of mental health services provided to students in school districts throughout Florida and to what extent they were provided to children and families. The study also investigated the extent to which student services directors perceived student services personnel to be qualified to provide mental health services to students and families and how student services directors' perceptions differed from those of student services supervisors (e.g., supervisor of psychological services, supervisor of guidance and counseling services, supervisor of social work services). Finally, the study examined the perceptions held by student services directors and supervisors about the impact of specified mental health services on student academic and behavioral outcomes.

The purpose of this chapter is to present the procedures that were used to conduct this study. The chapter will begin with a description of the participants and the research design for the study. Next, a discussion of the instrument that was utilized in this study is presented. The chapter will end with a description of the procedures that were used for data collection and data analysis.

Participants

The recruited participants in this study were 155 student services directors and supervisors of psychological services, school social work, and guidance and counseling employed in the 67 school districts in the State of Florida. The final sample from the original 155 consisted of 90 student support services administrators (e.g., student services

directors, directors/supervisors of psychological services, school social work, and guidance and counseling) who were employed throughout the State of Florida.

Participants were provided an informed consent form (see Appendices C & D) containing information as to the purpose of the study. In addition, all potential participants had to meet the inclusion criteria set forth by the researcher to enroll in the study (participants must have been student support services administrators and they must have been employed in the State of Florida). Further, potential participants were informed as to the steps taken to ensure their confidentiality.

Research Design

This study was a survey design in which data were collected through a self-report questionnaire completed by student services directors, exceptional education directors and the supervisors of psychological services, school social work, and guidance and counseling.

Instrumentation

A review of the existing literature did not result in the identification of any published instruments that could be used for data collection for this study. Therefore, the researcher developed for data collection purposes *The Perception of School Mental Health Services* (PSMHS) Survey (Versions A and B) (see Appendices A & B). The PSMHS Survey was designed to gather data on demographic information of student services directors and supervisors of student services (e.g., highest degree earned, years of experience in current position), district demographic information (e.g., size of school district), the types of mental health services offered in the district (e.g., individual counseling, consultation, authentic assessment) and beliefs about which type of professional (i.e., school

psychologist, school counselor, or school social worker) was qualified to provide various types of mental health services based on professional training. In addition, data were collected on the perceptions of administrators regarding which mental health services were related directly to student academic and behavioral outcomes.

The PSMHS survey Version A was developed for administration to student services directors. It was composed of a total of 21 items, 7 items that collected professional demographics information (items 1-7), 11 items which related to district demographic information (items 8-18) and 4 items addressed issues related to mental health services, specifically, the types of mental health services provided to students and/or their families (item 19), the professionals who were believed to be most qualified to provide these mental health services (item 20), the perceived impact of the services on student outcomes (item 21), and the types of support services which were utilized after a student returned to school after receiving an involuntary examination (item 22).

The PSMHS survey Version B was developed for administration to supervisors of student services. It was composed of a total of 11 items, 7 items which collect professional demographics information (items 1-7) and 4 items that address issues related to mental health services, specifically, the types of mental health services provided to students and/or their families (item 8), the professionals who were believed to be most qualified to provide these mental health services (item 9), the perceived impact of the services on student academic and behavioral outcomes (item 10), and the types of support services which were utilized after a student returned to school after receiving an involuntary examination (item 11).

Development of Instrument. The researcher of this study developed the instrument. Items for this survey were gleaned from a review of the literature on mental health services. Content validity evidence was gathered through the use of an expert review panel consisting of directors/supervisors of student services, school psychology, guidance and counseling and social work from Hillsborough, Pasco and Polk Counties (Neuendorf, 2002). The expert panel used a review sheet, which accompanied the survey, to assess the extent to which the instrument had adequate coverage of the domains it was intended to measure. The instrument was pilot tested (Appendices E & F) to assist in assessing the scale for understanding of content and response choices, wording of questions, and the total time needed to complete the survey. The information for the pilot test was gathered through the use of a panel, consisting of directors/supervisors of student services, school psychology, guidance and counseling and social work from Hillsborough, Pasco and Polk Counties (Neuendorf, 2002).

Data Collection Procedures

Prior to initiating the data collection phase of the study, approval was obtained through the USF Institutional Review Board (IRB) in order to ensure the ethical treatment of the participants in this study.

Step One: Data Collection. The procedures for this study were as follows: the researcher mailed to the student services directors and supervisors a packet which contained: 1) a copy of the PSMHS survey (version A or B), 2) a cover letter (Appendices C & D) which informed the participants about the purpose of the study, and solicited their participation in completing the survey, and information about the survey and information about confidentiality; 3) the USF IRB consent form, which participants

were asked to sign and return, and 4) a postage paid, pre-addressed return envelope with an assigned code for follow up purposes. As an incentive to respond, recipients were informed in the cover letter, that three participants who returned the completed survey would be randomly selected to receive a $25.00 American Express Gift Card. Ten additional participants who returned completed surveys would also be randomly selected to receive the book, *Response to Intervention:Policy Considerations and Implementation* (National Association of State Directors of Special Education, 2005).

Four weeks after the initial mailing of the survey packet, a reminder email was sent out to all participants, asking all non-respondents to complete and return the survey and informed consent form. Two weeks following the first reminder emailing, another final reminder email was sent out to all remaining non-respondents. The final reminder emailing also included an email attachment with the informed consent and survey.

Step Two: Data Management. Participants in the study who were mailed a survey were assigned a derived code number that was based upon the county in which they were employed and the order in which they appeared on their counties page in the Florida Student Support Services Directory. For example, if a participant was employed in Alachua County he or she would be assigned the code 01 because this county was the first to appear in the directory and then if that person's name was the first to appear on the Alachua County directory page then the number assigned to the person was 1, yielding an assigned code number "01-1". If the person was the third name to appear on the Alachua County page then the assigned number was "01-3". The code was assigned to each prospective participant and was recorded on return envelopes. The code was used to identify participants who had not responded for the purposes of subsequent mailings

(Fink, 1995). Once a completed survey was received, it was removed from the identifying envelope with the assigned code and placed in a box separate from the envelopes. This ensured that the identity of the participant remained anonymous relative to the selection of the reinforcement. All of the participants' data were entered into a computer spreadsheet. To assess the accuracy of the data entry, a second coder was trained to understand the data code sheets and they used those sheets to review the data transferred into the computer spreadsheet. An agreement of 100 % accuracy was achieved before the data entry was completed.

Data Analysis

Data were analyzed using SAS® software, Version 9.1 (SAS Institute, 2002-2003). Summary data in the form of descriptive statistics (e.g., frequencies, means and standard deviations were used to describe the respondent sample and the district demographic data. Descriptive statistics were used to report professional demographic information, using items 1-6 from survey versions A & B and for district demographic information, using items 8-18 from survey version A.

To analyze the data for this study, each research question will be presented and the survey item, which was used to answer each question, is also presented. Finally, the statistical analysis that was used to answer each research question is explained.

Research Question One. (a) What is the nature and extent of mental health services provided to students by school districts in the state of Florida? (b) Is there a difference in the profile of mental health services provided by school districts based on district size?

Survey item 19 (Version A)/ 7 (Version B) was used to identify types of mental health services provided. The types of mental health services, which were examined, included: (a) counseling; (b) consultation; (c) norm-referenced assessments; (d) authentic assessments; (e) prevention services; (f) intervention services and (g) other.

Descriptive statistics (e.g., mean and standard deviation) were computed to describe the data for survey item 19 (Version A)/ 7 (Version B). For each service, means and standard deviations of ratings of extent of service provided were computed.

Summary data on the nature of services provided and the extent to which each service is provided in a district were broken down by size of district (small, small/medium, medium, large, very large) (survey item 1, versions A and B), to provide a profile of services offered.

Research Question Two. To what extent do student services directors' beliefs about the qualifications of student services personnel to provide mental health services differ from those of student services supervisors (i.e., supervisor of psychological services, supervisor of guidance and counseling services, and supervisor of social work services)?

Survey item 7 (versions A and B) and item 20 (version A)/ 9 (version B) were used for the data analyses for research question two. Specifically, survey item 7 was used to identify respondents' professional role (student services directors vs. supervisors). Each survey item was used to examine the differences between professional roles and the impact this variable (role) relative to beliefs of how qualified student services personnel were to provide mental health services to students and families (item 20 (version A)/ 9 (version B)).

Descriptive statistics (e.g., mean and standard deviation) were used to report the ratings of levels of qualification of the service providers (school psychologists, school counselors, and school social workers) to provide mental health (MH) services as perceived by student services directors and supervisors as a combined group and by individual groups.

To determine if there were significant differences in the perceived level of qualifications of school psychologists, school counselors, and school social workers to provide mental health services from the perspective of student services directors and supervisors a one between- two-within subjects analysis of variance (ANOVA) procedure was conducted. The between-subjects factor was professional role (i.e., student services directors versus supervisors) and the within-subjects factors were type of service provider (i.e., school psychologists, school counselors, and school social workers) and type of mental health services (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). The ANOVA was tested at an alpha level of .05. The Huynh-Feldt test was used to determine statistical significance for within-subjects effects. Post hoc analyses were conducted using the Huynh-Feldt test for the within subjects factors as a follow-up to significant effects in the ANOVA.

Research Question Three. To what extent does the credential held by student services directors and supervisors moderate their beliefs about qualifications of individual student services providers to provide mental health services to students and their families?

Survey items 4 and 7 (versions A and B) and item 20 (version A)/ 9 (version B) were used for the data analysis of research question three. Specifically, survey item 4 was

used to identify the area(s) in which a professional is credentialed and survey item 7 was used to identify respondents' professional role. Each survey item was used to examine the differences between professional roles and area of credentialing and the impact of these two variables (role and credentialing) on his or her beliefs of how qualified student services personnel were to provide mental health services to students and families (item 20 (version A)/ 9 (version B)).

To determine if there were significant differences in the perceived level of qualifications of individual service providers (school psychologists, school counselors, and school social workers) to provide mental health services from the perspective of directors and supervisors by type of credential held data were subjected to three separate two between– one-within-subjects analysis of variance (ANOVA) procedures, one for each type of service provider. The between-subjects factors were professional role (i.e., directors versus supervisors) and type of credential held (teaching only vs. student support) and the within-subjects factor was type of mental health service (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). To protect against violation of Type I error rate, the Bonferroni method was used and each ANOVA was tested at an alpha level of .0167. The Huynh-Feldt test was used to determine statistical significance for within-subjects effects. Post hoc analyses were conducted using the Huynh-Feldt test for the within subjects factors as a follow-up to significant effects in the ANOVA.

Research Question Four. To what extent do student services directors and supervisors differ in their perceptions of the perceived impact of specified mental health

services (e.g., counseling, consultation, interventions) on students' academic and behavioral outcomes?

Survey items 7 (versions A and B) and item 21 (version A)/ 10 (version B) were used for the data analyses of research question three. Specifically, survey item 7 was used to examine professional role. Survey item 21 (version A)/ 10 (version B) was used to examine beliefs regarding the impact of mental health services on student academic and behavioral outcomes. Each survey item was used to examine the differences between professional roles (directors versus supervisors) and their beliefs regarding the impact of mental health services on academic and behavioral outcomes of students.

Means and standard deviations of ratings of the perceived level of impact of the mental health services on student's academic and behavioral outcomes by student services directors and supervisors as a combined and individual group were computed.

To determine if there were significant differences in the perceived level of impact of mental health services on academic outcomes from the perspective of directors and supervisors an analysis of variance (ANOVA) procedure was conducted. The between-subjects factor was professional role (i.e., student services directors versus supervisors) and the within-subjects factor was type of mental health service (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). The ANOVA was tested at an alpha level of .05. The Huynh-Feldt test was used to determine statistical significance for within-subjects effects.

Research Question Five. To what extent does the type of credential held by student services directors and supervisors moderate their beliefs regarding the impact of mental health services on academic and behavioral outcomes of students?

Survey items 4 and 7 (versions A and B) and item 21 (version A)/ 10 (version B) were used for the data analyses of research question five. Specifically, survey item 4 was used to identify the area in which a professional was credentialed and survey item 7 was used to examine professional role. Survey item 21 (version A)/ 10 (version B) was used to examine beliefs regarding the impact of mental health services on student academic and behavioral outcomes. Each survey item was used to examine the differences between professional roles and area of credentialing and the impact of these two variables (role and credentialing) on his or her beliefs regarding the impact of mental health services on academic and behavioral outcomes of students.

To determine if there were significant differences in the perceived level of impact of mental health services on academic and behavioral outcomes from the perspective of directors and supervisors by type of credential held two individual two-between –one-within-subjects analysis of variance (ANOVA) procedure was conducted. The between-subjects factors were professional role (i.e., directors versus supervisors) and type of credential (teaching only vs. student support) and the within-subjects factor was type of mental health service (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). The ANOVA was tested at the alpha level of .05. The Huynh-Feldt test was used to determine statistical significance for within-subjects effects. Post hoc analyses were conducted using the Huynh-Feldt test for the within subjects factors as a follow-up to significant effects in the ANOVA.

Delimitations of Study

A delimitation of this study was that only educational administrators who were employed as student services directors and supervisors of student services in the state of

Florida were participants in the current research study. Therefore, the results of this study can only be generalized to student services directors and supervisors of student services and not to other educational administrators in Florida (Cozby, 2001).

Limitations of Study

A potential threat to internal validity was that participants may have been inclined to provide socially desirable responses (Cozby, 2001). By administering a survey about mental health service delivery in the schools, the researcher was assuming that educational administrators believe that mental health services are being provided at some level, within schools. If a district was providing few or no mental health services, respondents may have been inclined to over-represent or under-represent the range of mental health services offered to students in their district. They also may have been inclined to misrepresent their beliefs about the link between specific mental health services and student outcomes (e.g., academic or behavior). Allowing participants to know the purpose of the study may have contributed to them providing inaccurate or false information about their actual perceptions of the relationship between mental health services and student outcomes (Cozby, 2001).

Chapter Four

Results

The present study was designed to examine the types of mental health services provided to students in school districts throughout Florida and the extent to which those services were provided to children and families. The study also investigated the beliefs of student services directors and supervisors regarding the qualifications of specific student services personnel to provide mental health services and extent to which those beliefs differed between student services directors and supervisors (i.e., supervisor of psychological services, supervisor of guidance and counseling services, and supervisor of social work services). Finally, the study examined the perceptions of student services directors and supervisors about the impact of specified mental health services on student academic and behavioral outcomes. The purpose of this chapter is to describe the results of the statistical analyses conducted for this study. The chapter addresses and answers the following research questions:

1. (a) What is the nature and extent of mental health services provided to students by school districts in the state of Florida?

   (b) Is there a difference in the profile of mental health services provided by school districts based on district size?
2. To what extent do student services directors' beliefs about the qualifications of student services personnel to provide mental health services differ from those of student services supervisors (i.e., supervisor of psychological services, supervisor of guidance and counseling services, and supervisor of social work services)?

3. To what extent does the credential held by student services directors and supervisors moderate their beliefs about qualifications of individual student services providers to provide mental health services to students and their families?
4. To what extent do student services directors and supervisors differ in their perceptions of the perceived impact of specified mental health services (e.g., counseling, consultation, interventions) on students' academic and behavioral outcomes?
5. To what extent does the type of credential held by student services directors and supervisors moderate their beliefs regarding the impact of mental health services on academic and behavioral outcomes of students?

Survey Response Rate

A total of 155 surveys were mailed to student services directors and supervisors in the State of Florida. Thirty-two surveys were received as a result of the first mailing and 58 on the second mailing. A total of 90 surveys were completed and returned (out of a possible 155), representing a 58.1% response rate. A 50% response rate is generally considered adequate for analysis of research results (Babbie, 1982). Table 1 reports the number and percent of completed surveys for both directors and supervisors.

Table 1

Response Rate of Sample Participants by Role

Role	Number of Surveys Mailed	Completed Surveys Returned	Response Rate
Directors	67	26	38.8%
Supervisors			
School Psychology	43	29	67.4%
Guidance and Counseling	24	19	79.2%
Social Work	21	16	76.2%
Total	88	64	72.7%
Overall	155	90	58.1%

Data reported in Table 1 reveal that directors had the lowest response rate (38.8%) of all of the professionals in the sample; therefore, the results from the directors should be considered preliminary and interpreted cautiously.

Academic and Professional Credentials of Respondent Sample

Data regarding the academic and professional credentials of student services directors and supervisors in the respondent sample are reported in Tables 2 and 3, respectively.

Student Services Directors. As shown in Table 2, the majority (73%) of student services directors held master's degrees. Twenty-three percent held an educational specialist or doctoral degree. The areas in which directors predominantly earned their degree were in administration (42%) and special education (23%). This differs somewhat from the profile of supervisors whose degree areas were almost evenly distributed across counseling, school psychology, social work, and administration (see Table 3).

Directors are approximately equally credentialed between teaching only (43%) and student support services (56%). Fifty-six percent of the directors are new to their current position (1-5 years), while 40% have been in their positions for 11 years or more. Eighty-eight percent report they have been in the field of education for more than 11 years and 85 % reported being in the field for more than 15 years.

Student Services Supervisors. As is reported in Table 3, 44% of student services supervisors in the sample held a master's degree, 31% held an educational specialist degree and 19% held a doctorate degree. Twenty-three percent of the supervisors had earned a degree in counseling, 20% in school psychology, 19% in social work, and 27% in administration.

The majority of supervisors (84%) held credentials in student support services and 16% held credentials in teaching only. In terms of the number of years spent in their current position, 38% of the supervisors are new to their current position (1-5 years), while approximately 44% have been in their current position for 11 years or more. In terms of the number of years spent in the field of education, 89% of the supervisors reported that they had been in the field of education for more than 11 years; and 66% for more than 15 years.

Table 2

Academic and Professional Credentials of Directors (N=26)

Credential	n	%
Highest Degree Earned		
Bachelor's	1	3.85
Master's	19	73.08
Educational Specialist	1	3.85
Doctorate	5	19.23
Area Degree Earned		
Special Education	6	23.08
General Education	1	3.85
Counseling	5	19.23
School Psychology	2	7.69
Social Work	1	3.85
Administration	11	42.31
Area in which Credentialed		
Teaching only	10	43.48
Student Services	13	56.52
Years of Experience in Current Position		
1-5 years	14	56.00
6-10 years	1	4.00
11-15 years	6	24.00
More than 15 years	4	16.00
Years of Experience in Educational Setting		
1-5 years	2	7.69
6-10 years	1	3.85
11-15 years	1	3.85
More than 15 years	22	84.62

Table 3

Academic and Professional Credentials of Supervisors (N=64)

Credential	N	%
Highest Degree Earned		
Bachelor's	4	6.25
Master's	28	43.75
Educational Specialist	20	31.25
Doctorate	12	18.75
Area Degree Earned		
Special Education	4	6.25
General Education	3	4.69
Counseling	15	23.44
School Psychology	13	20.31
Social Work	12	18.75
Administration	17	26.56
Area in which credentialed		
Teaching only	10	15.63
Student Services	54	84.38
Years of Experience in Current Position		
1-5 years	24	37.50
6-10 years	12	18.75
11-15 years	11	17.19
More than 15 years	17	26.56
Years of Experience in Educational Setting		
1-5 years	1	1.56
6-10 years	6	9.38
11-15 years	15	23.44
More than 15 years	42	65.63

Student Enrollment by Size of District

Table 4, provides summary data for students enrolled in districts represented in the sample for the academic school year of 2005-2006, as reported by the student services directors.

Minority Students. Minority students make up approximately 71% of the student population in the very large districts in the sample. The middle sized districts have the smallest overall percentage of minority students (23%).

Free and Reduced Lunch. Although the very large districts have the highest percentage of minority students, the small and large districts were observed to have the highest percentage (45% and 41%, respectively) of students who were from low income homes (on free and reduced lunch).

Emotionally Handicapped/Severe Emotional Disturbance. Although all of the districts have few students being served in emotionally handicapped or severely emotionally disturbed classrooms, the very large districts serve the highest percentage (10%) of students in comparison to the other districts.

Suspensions. The highest rates of suspensions occurred in the small/middle (13%) and large (10%) sized districts.

Expulsions and Alternative Education. Overall, very few students (<2%) were reported to be in alternative education or expelled from school.

Baker Acts. Very few directors reported the number or percent of students who were Baker Acted in their districts in the 2005-2006 academic year. Thus, data reported on the number of students Baker Acted in Table 4 are not representative of the student population in the districts included in this sample.

Table 4

Number and Percent of Students by Demographic Category (AY 2005-2006)

Demographics	N	n	%
	Small Districts (n= 6)		
Total Enrollment	22706		
Minority Students		9105	40.10
Students on Free Lunch		10018	44.12
Students in EH/SED		310	1.37
Students in Alternative School		278	1.22
Students Suspended		472	2.08
Students Expelled		64	0.02
Students Baker Acted		23	<0.001
	Small/Middle Districts (n= 6)		
Total Enrollment	42846		
Minority Students		19072	44.51
Students on Free Lunch		8364	19.52
Students in EH/SED		2297	5.36
Students in Alternative School		525	1.23
Students Suspended		5408	12.62
Students Expelled		43	0.03
Students Baker Acted		3	<0.001
	Middle Districts (n= 7)		
Total Enrollment	192096		
Minority Students		45109	23.48
Students on Free Lunch		60012	31.24
Students in EH/SED		2644	1.38
Students in Alternative School		1004	0.52
Students Suspended		8024	4.17
Students Expelled		197	0.01
Students Baker Acted		20	<0.001

Large Districts (n= 5)			
Total Enrollment	404933		
Minority Students		199122	49.17
Students on Free Lunch		165654	40.90
Students in EH/SED		10571	2.61
Students in Alternative School		5224	1.36
Students Suspended		41728	10.30
Students Expelled		1223	0.03
Students Baker Acted		171	<0.001
Very Large Districts (n=5)			
Total Enrollment	777577		
Minority Students		558713	71.85
Students on Free Lunch		175628	22.59
Students in EH/SED		75891	9.75
Students in Alternative School		15437	1.99
Students Suspended		41602	5.35
Students Expelled		7784	1.00
Students Baker Acted		300	<0.001

Ratio of FTE Student Services Personnel to Student by Size of District

Data regarding the school personnel to student ratio by district size are presented in Table 5. The district size (i.e., small, small/middle, middle, large, and very large) was determined based on the criteria used by the Florida Department of Education. According to the professional associations representing the student services professionals, the recommended school psychologist to student ratio is 1:1500, the recommended school counselor to student ratio is 1:560, and the recommended school social worker to student ratio is 1:2000 (Curtis, Grier, Abshier, Sutton, & Hunley, 2002; Kestenbaum, 2000; Franklin, 2000).

Table 5

Ratio of FTE Student Services Personnel: Student by Size of District (AY 2005-2006)

Demographics	Mean Ratio	Range
	Small Districts (n= 6)	
School Psychologists	1:1747	1:1471-1:2500
School Counselors	1:541	1:439-1:871
School Social Workers	1:3515[a]	1:3515-1:3515
	Small/Middle Districts (n= 6)	
School Psychologists	1:1785	1:1399-1:2400
School Counselors	1:481	1:399-1:541
School Social Workers	1:3713	1:3000-1:5596
	Middle Districts (n= 7)	
School Psychologists	1:2561	1:2443-1:3072
School Counselors	1:447	1:349-1:524
School Social Workers	1:4087	1:3413-1:7330
	Large Districts (n= 5)	
School Psychologists	1:1866	1:1359-1:2143
School Counselors	1:356	1:212-1:494
School Social Workers	1:3288	1:1286-1:3500
	Very Large Districts (n=5)	
School Psychologists	1:1637	1:572-1:1716
School Counselors	1:426	1:361-1:750
School Social Workers	1:2051	1:1809-1:5660

Note: FTE=Full-Time Equivalent

[a] There was only one small district out of six that had FTE school social workers

Data from this current study reveal that the district school psychologist to student ratio is often over the recommended NASP ratio across district sizes, with the highest mean school psychologist to student ratio (M=1:2561) occurring in the middle sized districts. The mean ratios of school counselor to student ratio are often within the recommended ratios. However, the ratio of school counselors to students in the small districts (Range= 1:439-1:871) and the very large districts (Range= 1:361-1:750) districts have ratios that are above the recommended ratios for school counselors. Finally, school social workers often have numbers that are much higher than the recommended ratios, with the highest mean ratio (M= 1:4087) in the middle sized districts.

Research Question 1: Mental Health Services Provided to Students by their School District

The first research question addressed the level of mental health service provision by district size (small, small/medium, medium, large, and very large). To answer this question, means and standard deviations of participants' ratings of the level of mental services provided were calculated. The ratings were based on a 5-point Likert-type scale (5= Provided to all student(s)/ families needing the service; 4= Provided to most student(s)/families needing the service; 3= Provided to some student(s)/families when the service in available; 2= Provided to student(s)/families on a very limited basis; 1= Not provided to student(s)/ families/service is unavailable). The types of mental health services which were examined included: (a) counseling, (b) consultation, (c) norm-referenced assessments, (d) authentic assessments, (e) prevention services, (f) intervention services and (g) "Other". The "Other" category included items such as

behavior rating scales, clinical interviews, case management, and research evaluation. The results are presented in Table 6 and Figure 1.

Table 6

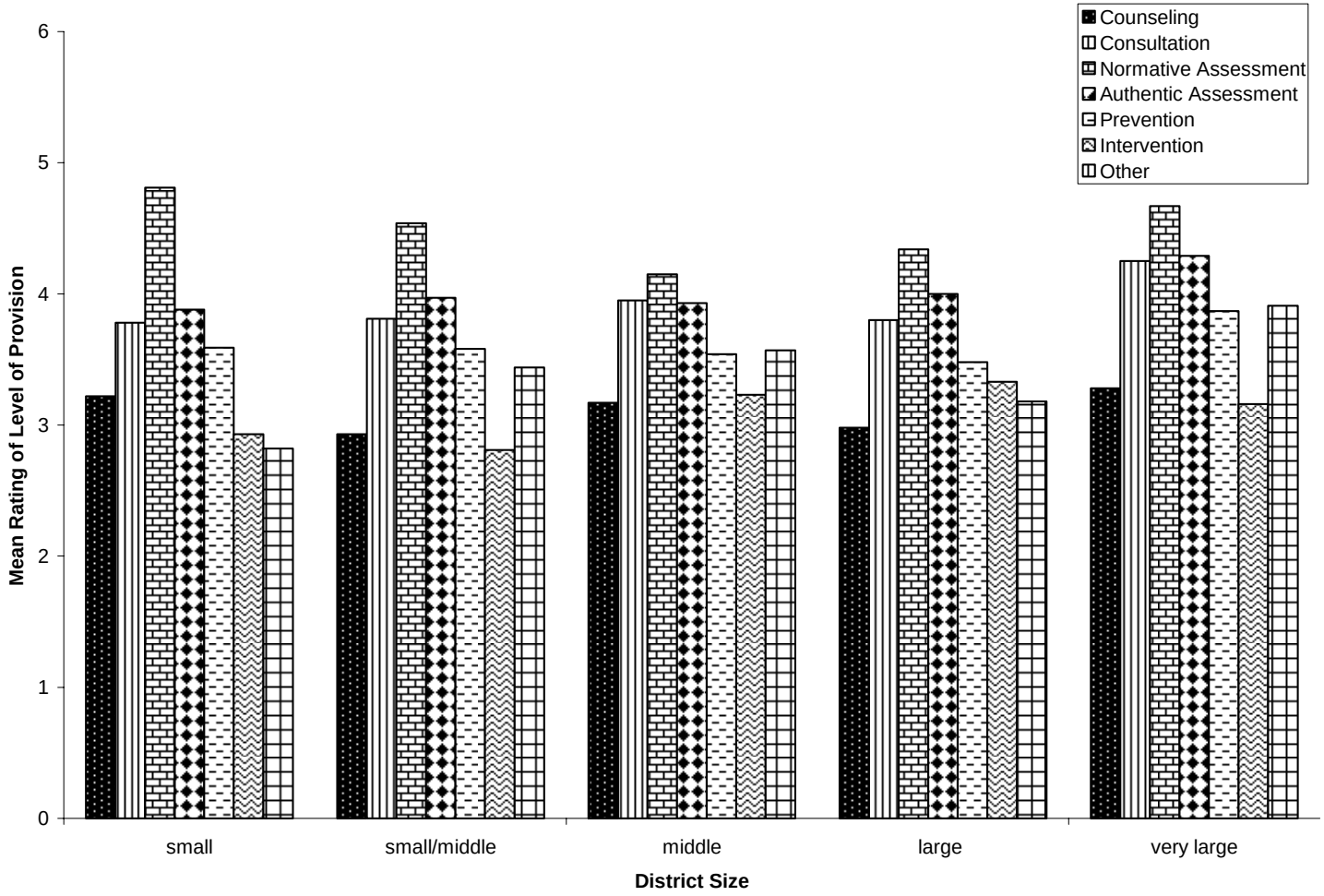
Level of Mental Health Service Provision by District Size

	Small	Small/Middle	Middle	Large	Very Large
	M	M	M	M	M
MH Services	*(SD)*	*(SD)*	*(SD)*	*(SD)*	*(SD)*
Counseling	3.22	2.93	3.17	2.98	3.28
	(1.07)	*(0.71)*	*(1.02)*	*(1.08)*	*(0.71)*
Consultation	3.78	3.81	3.95	3.80	4.25
	(1.02)	*(0.75)*	*(0.94)*	*(0.84)*	*(0.67)*
Normative Assessment	4.81	4.54	4.15	4.34	4.67
	(0.47)	*(0.73)*	*(1.14)*	*(0.64)*	*(0.50)*
Authentic Assessment	3.88	3.97	3.93	4.00	4.29
	(1.32)	*(1.01)*	*(1.39)*	*(0.97)*	*(0.65)*
Prevention	3.59	3.58	3.54	3.48	3.87
	(0.67)	*(0.58)*	*(0.74)*	*(0.77)*	*(0.57)*
Intervention	2.93	2.81	3.23	3.33	3.16
	(0.83)	*(0.58)*	*(0.79)*	*(0.72)*	*(0.58)*
Other	2.82	3.44	3.57	3.18	3.91
	(0.87)	*(0.69)*	*(1.01)*	*(0.63)*	*(0.84)*

Note: Response Scale:
5: Provided to all student(s)/ families needing the service
4: Provided to most student(s)/families needing the service
3: Provided to some student(s)/families when the service in available
2: Provided to student(s)/families on a very limited basis
1: Not provided to student(s)/ families/service is unavailable

Figure 1

Level of Mental Health Service Provision by District Size

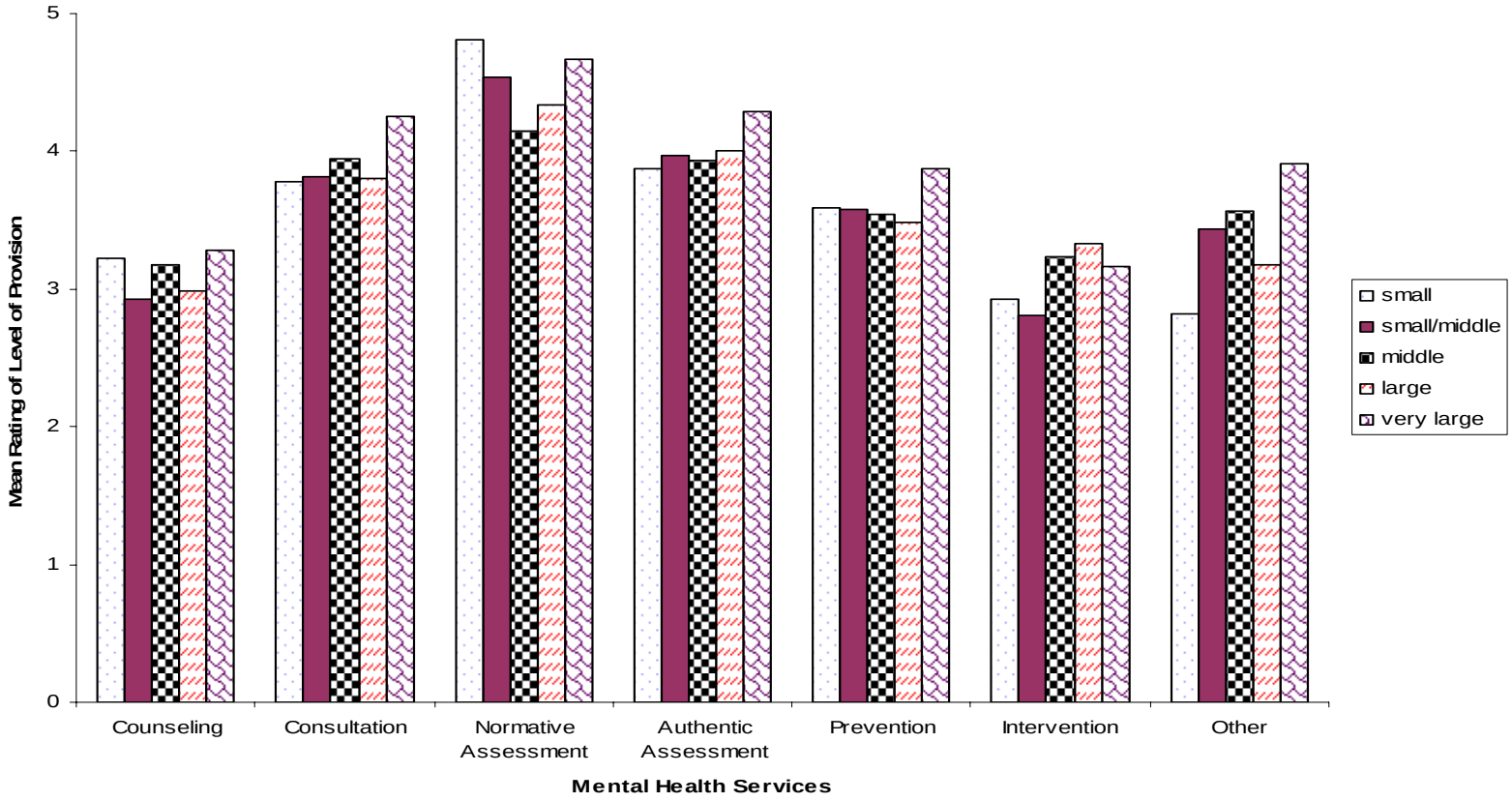


All districts reported providing a variety of services to students, but to differing degrees. A closer examination of the data reveal (Table 6 and Figure 1) that the three services most frequently provided across all districts were normative assessments, authentic assessments, and consultation. Normative assessments are the mental health service that is most likely to be provided to most students and families (Range= 4.15-4.81). In contrast, interventions (Range= 2.81-3.33) and counseling (Range= 2.93-3.28) are the mental health services that are least likely to be provided to most students and families who need it. In fact, a closer examination of Table 6 reveals that the interventions and counseling services are provided to some families when the service is available or is provided on a limited basis.

In addition, Figure 2 reveals that the very large districts provided consultation, authentic assessment, prevention and 'other' services to most students and families that needed it. For normative assessments, small, small/middle and very large districts provided this service to most students and families that needed it. Overall, both Figures 1 and 2 reveal that very large districts are most likely to provide a number of different mental health services to all or most students and families who need it, while smaller districts are less likely to provide a number of mental health services to all or most students and families that need it.

Figure 2

Profile of Mental Health Service by District Size



Research Question 2: Perceived Qualifications of Student Services Personnel to Provide Mental Health Services

The second research question sought to determine the extent to which student services directors and supervisors (i.e. school psychology, counseling and guidance, and social work) perceived school psychologists, school counselors, and school social workers as qualified to provide specific mental health services. The ratings were based upon a 5-point Likert-type scale (5= highly qualified no supervision needed; 4= qualified and minimal supervision needed; 3= somewhat qualified and supervision is needed; 2= minimally qualified and intense supervision needed; 1= Not qualified). The response scale was developed to reflect the level of qualification and supervision perceived necessary for the given student services provider to provide quality services.

To answer the research question, means and standard deviations of ratings of levels of qualification as perceived by student services directors and supervisors as a combined group and by individual groups were computed. Then data were subjected to analysis of variance procedures to determine if there were significant differences in perceptions between directors and supervisors.

Mean ratings of the perceived level of qualifications of the service providers (school psychologists, school counselors, and school social workers) to provide mental health (MH) services as perceived by student services directors and all supervisors combined are reported in Tables 7, 9, and 11. Mean ratings by directors and individual supervisors (school psychologists, school counselors, and school social workers) are reported in Tables 8, 10, and 12.

School Psychologist. Data reported in Tables 7 and 8 reveal that directors often rate school psychologists as being more qualified to provide a number of individual mental health services in comparison to the ratings of student services supervisors. Overall, the ratings from directors and supervisors, as a group, suggest that school psychologists are perceived as being qualified or somewhat qualified to provide most of the identified mental health services. As is shown in Table 7 reveals that directors perceived that school psychologists to be qualified (needing only minimal supervision) to provide normative assessment (M= 4.88), "Other" services (M= 4.50), consultation (M= 4.38), counseling (M= 4.26) and authentic assessment (M= 4.10).

Supervisors, as a group, rated school psychologists as qualified (needing only minimal supervision) to provide normative assessment (M =4.91), consultation (M= 4.20) and "Other" services (M= 4.07). School psychologists were rated by directors as somewhat qualified (needing supervision) to provide intervention (M= 3.83) and prevention (M= 3.67), while supervisors, as a group, rated them as somewhat qualified (needing supervision) to provide services in intervention (M= 3.72), authentic assessment (M= 3.58), counseling (M= 3.47), and prevention (M= 3.37). A closer examination of Table 8 reveals that supervisors of social work rated school psychologists as minimally qualified (needing intense supervision) (M= 2.94) to provide counseling services.

Table 7

*Mean Ratings of Perceived Qualifications of **School Psychologists** to Provide MH Services by Professional Role*

	Directors Student Services		Supervisors	
MH Services	M	SD	M	SD
Counseling	4.26	0.78	3.47	1.28
Consultation	4.38	0.56	4.20	0.64
Normative Assessment	4.88	0.24	4.91	0.23
Authentic Assessment	4.10	0.94	3.58	1.29
Prevention	3.67	0.67	3.37	1.06
Intervention	3.83	0.83	3.72	0.87
Other	4.50	0.87	4.07	0.84
Overall Mental Health Service	4.23	0.70	3.90	0.89

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Table 8

*Mean and Standard Deviations of Ratings of Level of Qualifications of **School Psychologists** to Provide MH Services as Perceived by Directors and Supervisors*

	Directors Student Services		Supervisors Psychology		Supervisors School Counseling		Supervisors Social Work	
	M	SD	M	SD	M	SD	M	SD
MH Services								
Counseling	4.26	0.78	3.78	1.07	3.67	1.44	2.94	1.32
Consultation	4.38	0.56	4.19	0.64	4.22	0.73	4.27	0.54
Normative Assessment	4.88	0.24	4.91	0.21	4.92	0.24	4.93	0.25
Authentic Assessment	4.10	0.94	3.65	1.36	3.06	1.27	4.09	1.00
Prevention	3.67	0.67	3.58	1.02	3.46	1.12	3.01	1.03
Intervention	3.83	0.83	3.78	0.77	3.69	1.10	3.75	0.81
Other	4.50	0.87	4.21	0.73	3.95	1.03	4.01	0.79
Range of Ratings	3.67-4.88		3.65-4.91		3.06-4.92		2.94-4.93	

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

School Counselor. Data reported in Table 9 reveal that directors rated school counselors as qualified (needing only minimal supervision) to provide prevention services (M= 4.02) and somewhat qualified (needing supervision) to provide all other mental health services except normative assessments for which they are rated as minimally qualified (needing intense supervision; M=2.51). Services in prevention (M= 4.02), intervention (M = 3.90), and counseling (M= 3.79) were the top three mental health services which school counselors were considered to have the highest qualifications to provide. Supervisors, as a group, also rated school counselors as having highest qualifications to provide intervention and consultation services (M= 3.83 and 3.74, respectively). Supervisors, however, did not rate counseling as one of the top three services for school counselors, instead rating prevention (M =3.69) as one of the top three.

Supervisors of guidance and counseling, in general, tended to rate the qualifications of school counselors higher on all MH services than did directors and the supervisors of psychology and social work (see Table 10). Specifically, they are seen by supervisors of school counseling as qualified (needing only minimal supervision) in the provision of intervention (M= 4.11), counseling (M= 4.09), and consultation (M= 4.05) services, and they are seen as minimally qualified (needing intense supervision) to provide normative assessments (M= 2.90). In contrast, supervisors of psychology and social work rate counselors as somewhat qualified (needing supervision) to provide all mental health services except normative assessments for which they are rated as minimally qualified (needing intense supervision; M=2.38 and 2.09).

Table 9

*Mean Ratings of Perceived Qualifications of **School Counselors** to Provide MH Services by Professional Role*

	Directors Student Services		Supervisors	
MH Services	M	SD	M	SD
Counseling	3.79	0.74	3.53	0.87
Consultation	3.64	0.67	3.74	0.67
Normative Assessment	2.51	0.85	2.40	0.92
Authentic Assessment	3.60	1.16	3.46	1.22
Prevention	4.02	0.48	3.69	0.71
Intervention	3.90	0.63	3.83	0.82
Other	3.45	0.63	3.24	0.89
Overall Mental Health Service	3.56	0.74	3.41	0.87

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Table 10

*Mean and Standard Deviations of Ratings of Level of Qualifications of **School Counselors** to Provide MH Services as Perceived by Directors and Supervisors*

	Directors Student Services		Supervisors Psychology		Supervisors School Counseling		Supervisors Social Work	
MH Services	M	SD	M	SD	M	SD	M	SD
Counseling	3.79	0.75	3.20	0.75	4.09	0.73	3.56	0.97
Consultation	3.64	0.67	3.43	0.61	4.05	0.65	3.98	0.63
Normative Assessment	2.51	0.86	2.09	0.80	2.90	0.93	2.38	0.81
Authentic Assessment	3.60	1.16	3.45	1.28	3.56	1.29	3.47	1.07
Prevention	4.02	0.48	3.61	0.81	3.91	0.66	3.60	0.52
Intervention	3.90	0.63	3.72	0.96	4.11	0.73	3.76	0.52
Other	3.45	0.62	3.16	0.80	3.56	0.97	3.08	0.91
Range of Ratings	2.51-4.02		2.09-3.72		2.90-4.11		2.38-3.98	

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Social Worker. Data reported in Table 11 reveal that directors and supervisors gave similar ratings of perceived qualifications of social workers to provide a number of individual mental health services. For the most part, they were rated by directors and supervisors as a group and individually, as somewhat qualified (needing some supervision) to provide most mental health services and minimally qualified (needing intense supervision) to provide normative and authentic assessment services. As is seen in Table 12, supervisors of social work rate school social workers as qualified (needing minimal supervision) to provide services in the area of counseling (M= 4.22). Directors rated them as qualified (needing only minimal supervision) in the area of prevention (M= 4.02) and "Other" services (M= 4.02) and minimally qualified (needing intense supervision) in the provision of normative (M= 2.68) and authentic (M= 2.53) assessments.

Supervisors of psychology rated school social workers as somewhat qualified (supervision needed) to provide "Other" services (M= 3.88), counseling (M= 3.85), prevention (M= 3.77), consultation (M= 3.43) and interventions (M= 3.10) services; minimally qualified (intense supervision needed) to provide normative assessments (M= 2.17), and not qualified to provide authentic assessments (M= 1.92). Similarly, supervisors of guidance and counseling rated social workers as qualified (needing only minimal supervision) to provide "Other" services (M=4.02), and somewhat qualified (supervision needed) to provide counseling (M= 3.78), prevention (M= 3.77), consultation (M= 3.44), and intervention services (M= 3.05); while minimally qualified (intense supervision needed) to provide normative (M= 2.46) and authentic (M= 2.34) assessments.

Table 11

*Ratings of Perceived Qualifications of **School Social Workers** to Provide MH Services by Professional Role*

	Directors Student Services		Supervisors	
MH Services	M	SD	M	SD
Counseling	3.88	1.06	3.92	0.88
Consultation	3.53	1.11	3.53	0.94
Normative Assessment	2.68	0.94	2.42	1.11
Authentic Assessment	2.53	1.34	2.11	1.08
Prevention	4.02	0.61	3.86	0.75
Intervention	3.59	0.85	3.18	1.20
Other	4.02	0.76	4.00	0.76
Overall Mental Health Service	3.46	0.95	3.29	0.96

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Table 12

*Mean and Standard Deviations of Ratings of Level of Qualifications of **School Social Workers** to Provide MH Services as Perceived by Directors and Supervisors*

	Directors Student Services		Supervisors Psychology		Supervisors School Counseling		Supervisors Social Work	
MH Services	M	SD	M	SD	M	SD	M	SD
Counseling	3.88	1.06	3.85	0.58	3.78	0.93	4.22	1.15
Consultation	3.53	1.11	3.43	0.82	3.44	1.21	3.76	0.80
Normative Assessment	2.68	0.94	2.17	1.09	2.46	1.33	2.75	0.98
Authentic Assessment	2.53	1.34	1.92	0.85	2.34	1.45	2.17	1.07
Prevention	4.02	0.61	3.77	0.85	3.91	0.74	3.93	0.58
Intervention	3.59	0.85	3.10	1.20	3.05	1.48	3.46	0.79
Other	4.02	0.76	3.88	0.72	4.02	0.93	4.17	0.53
Range of Ratings	2.53-4.02		1.92-3.88		2.34-4.02		2.17-4.22	

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Figure 3 provides a matrix showing a summary of the mental health services that student service providers are perceived by student services directors and supervisors to be highly qualified or qualified to provide with little/no supervision (i.e., for mean ratings of 4 to 5). As is shown, school psychologists are consistently rated by directors and supervisors as being qualified, needing little supervision in the provision of normative assessments and consultation. A closer examination of the matrix reveals that directors and supervisors of social work also rated school psychologists as being qualified (needing minimal supervision) to provide authentic assessments. In addition, directors and supervisors of psychology and social work rated them similarly to provide "Other" services (e.g., behavioral ratings). Directors also provided high ratings of qualifications to school psychologists in the area of counseling.

For school counselors and social workers, there is no consistency amongst the directors and student services supervisors as to the MH services which school counselors and social workers are highly qualified or qualified to provide. It is interesting to note that none of the professional service providers were rated as highly qualified or qualified (needing only minimal supervision) to provide intervention services.

Figure 3

Matrix of Perceptions of Directors and Supervisors Regarding Qualifications of Student Support Personnel to Provide MH Services with No/Minimal Supervision

	School Psychologist				School Counselor				School Social Worker			
Mental Health Service	Directors	Supervisor Psychology	Supervisor Counseling	Supervisor Social Work	Directors	Supervisor Psychology	Supervisor Counseling	Supervisor Social Work	Directors	Supervisor Psychology	Supervisor Counseling	Supervisor Social Work
Counseling	X						X					X
Consultation	X	X	X	X			X					
Normative Assessment	X	X	X	X								
Authentic Assessment	X			X								
Prevention					X				X			
Intervention												
Other	X	X		X			X		X		X	X

Test of Differences in Perceptions Between Directors and Student Services Supervisors. To determine if there were significant differences in the perceived level of qualifications of school psychologists, school counselors, and school social workers to provide mental health services from the perspective of student services directors and supervisors, a one between- two-within-subjects analysis of variance (ANOVA) was conducted. The between-subjects factor was professional role (i.e., student services directors versus supervisors) and the within-subjects factors were type of service provider (i.e., school psychologists, school counselors, and school social workers) and type of mental health services (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). The "Other" category was not included in these analyses as it covered a range of services not clearly delineated. The ANOVA was tested at an alpha level of .05. The Huynh-Feldt test was used to determine statistical significance for within-subjects effects, as the sphericity assumption was violated.

Examination of Table 13 reveals statistically significant interaction effects for Role x Provider x Service, $F (10, 670) = 2.14$, $p < .05$ and Provider x Service, $F (10, 670) = 62.13$, $p < .001$, employing the Huynh-Feldt adjustment. Statistical significance was not observed for the Service x Role interaction effect, $F (5, 335) = 0.42$, $p > .05$, or Provider x Role interaction effect, $F (2, 134) = 1.06$, $p > .05$. Significant main effects were observed for the type of mental health service, $F (5, 335) = 12.85$, $p < .05$, and type of service provider, $F (2, 134) = 28.50$, $p < .001$, employing the Huynh-Feldt adjustment, the main effect for professional role (directors vs. supervisors) was not statistically significant $F (1, 67) = 3.89$, $p > .05$.

Table 13

Analysis of Variance of Ratings of Perceived Qualifications of Service Providers to Provide MH Services by Professional Role

Source	df	SS	MS	F	HF
Between Ss					
Role (A)	1	3.89	3.89	1.24	
S/A (Error)	67	211.01	3.15		
Within Ss					
Provider (B)	2	90.12	45.06	28.50	< .001*
Provider*Role (AB)	2	3.35	1.67	1.06	ns
S/AB (Error)	134	211.83	1.58		
Service (C)	5	52.99	10.60	12.85	< .001*
Service*Role (AC)	5	1.74	0.35	0.42	ns
S/AC (Error)	335				
Provider*Service (BC)	10	228.53	22.85	62.13	< .001*
Role *Provider*Service (ABC)	10	7.89	0.79	2.14	.043*
SC/AB (Error)	670	246.45	0.37		
Total	1241	1057.80			

*p>.05

Note: Professional Role (Directors vs. Supervisors)

Role x Provider x Service Interaction Effect. To determine the providers between which there were statistically significant differences based on ratings of their perceived level of qualifications by student services directors and supervisors, post hoc analyses were conducted using Dunn's test. Huynh-Feldt adjustment was employed for the within-subjects factor since the sphericity assumption was violated. A graph of the interaction effect is shown in Figure 4. The interaction effect is disordinal.

Results of the Dunn's test indicate that for directors there were no significant differences in mean ratings of perceived qualifications of the three service providers (school psychologist, school counselor, and school social worker) to provide services in counseling, consultation, prevention, and intervention. However, significant differences in qualification ratings were observed for services in normative and authentic assessments (see Table 14). In the area of normative assessments, directors rated school psychologists as significantly higher in terms of their qualifications to provide these services than both school counselors and social workers (see Table 14). No differences in ratings were observed between school counselors and social workers. For authentic assessments, directors rated school psychologists and school counselors' significantly higher ($p < .05$) in the level of qualifications to provide these services than social workers; there were no differences in mean ratings between school psychologists and school counselors.

Figure 4

Interaction Effect of Role and Provider and Service on the Mean Ratings of the Qualifications of Service Providers to Provide MH Services

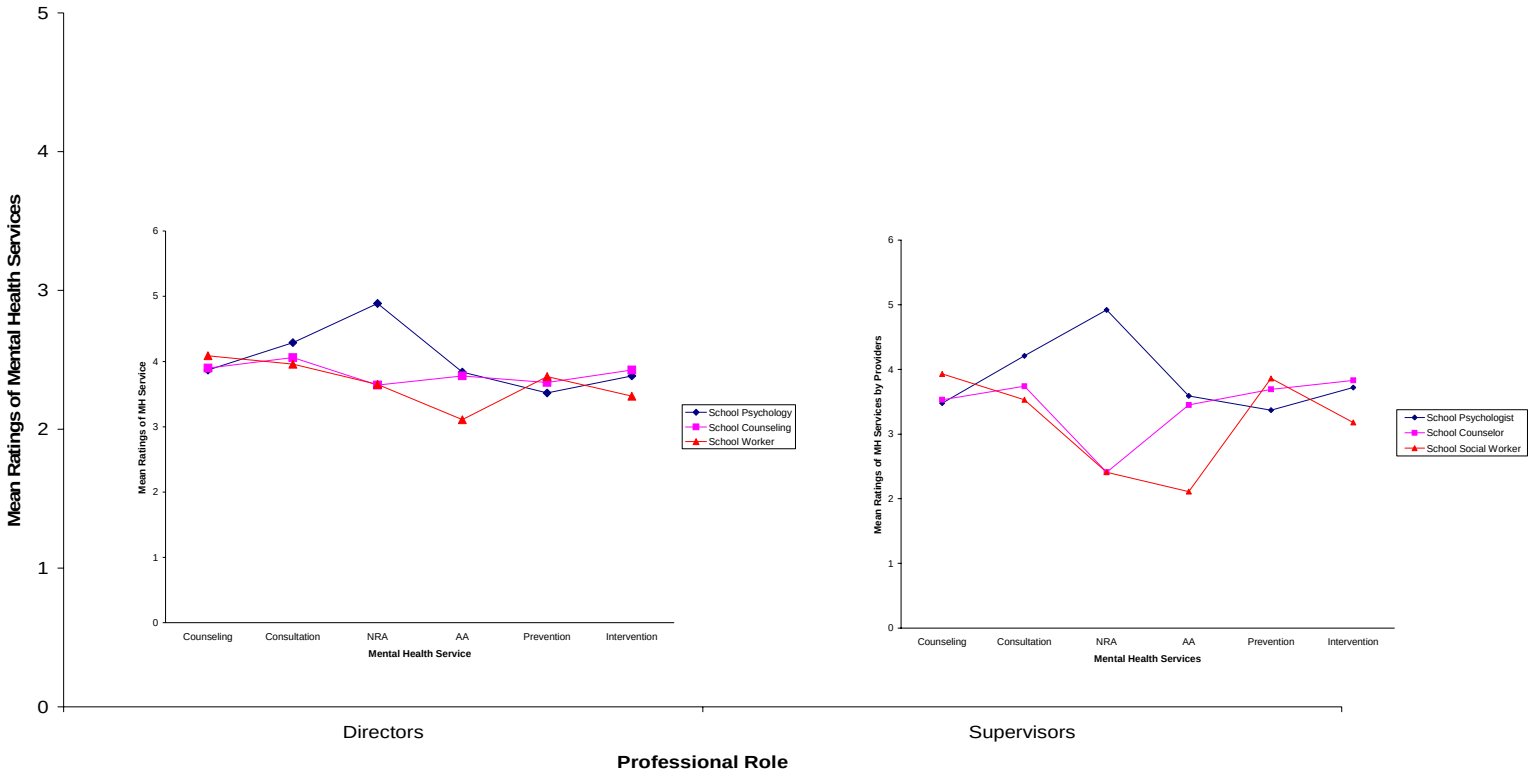


Table 14

Means of Ratings of Perceived Level of Qualifications of Service Providers to Provide MH Services by Professional Role

	Student Support Professionals			
	School Psychology	School Counselor	School Social Worker	Marginal Mean
MH Service	M	M	M	M
	Directors			
Counseling	4.26	3.78	3.88	
Consultation	4.39	3.64	3.53	
Normative Assessment	4.88	2.51	2.68	
Authentic Assessment	4.10	3.60	2.53	
Prevention	3.67	4.03	4.02	
Intervention	3.83	3.90	3.62	
Marginal Mean	4.19	3.58	3.38	3.72
	Supervisors			
Counseling	3.48	3.53	3.93	
Consultation	4.21	3.74	3.53	
Normative Assessment	4.92	2.41	2.41	
Authentic Assessment	3.59	3.45	2.11	
Prevention	3.37	3.69	3.86	
Intervention	3.72	3.83	3.18	
Marginal Mean	3.88	3.44	3.17	3.49
Overall MH Services	3.69	3.51	3.27	3.49

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Professional Role: (Directors vs. Supervisors)

With respect to supervisors of student services statistically significant differences were observed in their mean ratings of the perceived level of qualifications of the school psychologists, counselors, and social workers to provide services in the areas of consultation, normative assessments, authentic assessments, and interventions. More specifically, supervisors rated school psychologists as being more qualified to provide services in the area of consultation than social workers ($p<.05$); however, there were no differences in mean qualification ratings qualifications between school psychologists and school counselors or between school counselors and social workers to provide these services (see Table 14). Relative to normative assessments, school psychologists were rated by student services supervisors as being more highly qualified ($p < .05$) than school counselors and social workers to provide these services; no differences in perceived levels of qualifications to provide normative assessments were observed between school counselors and social workers. Supervisors rated both school psychologists and school counselors as being more qualified than social workers to provide authentic assessments; no significant differences in ratings of qualifications were observed between school psychologists and school counselors. In the area of intervention, they rated school counselors as being more qualified than social workers to provide these services; no significant differences in perceived qualifications were observed between school psychologists and school counselors or between school psychologists and school social workers. Finally, in the areas of counseling and prevention, there were no differences in supervisors mean ratings of the perceived level of qualifications among school psychologists, school counselors, and social workers.

Of note, although school psychologists were rated significantly higher than school counselors and school social workers to provide mental health services such as counseling, consultation, normative assessment, and authentic assessment, they were still perceived as needing at least minimal supervision to provide such services, and the most qualified to provide services in normative assessment.

Research Question 3: Perceived Qualifications of Student Services Personnel to Provide Mental Health Services as Moderated by Type of Credential Held

The third research question sought to determine the extent to which the type of credential held by student services directors and supervisors moderated their beliefs about qualifications of individual student services providers (school psychologists, counselors, and school social workers) to provide mental health services to students and their families. The ratings were based on a 5-point Likert-type scale (5= highly qualified no supervision needed; 4= qualified and minimal supervision needed; 3= somewhat qualified and supervision is needed; 2= minimally qualified and intense supervision needed; 1= Not qualified). The response scale was developed to reflect the level of qualification and supervision perceived necessary for the given student services provider to provide quality services.

Data were subjected to three separate two between– one-within-subjects analysis of variance (ANOVA) procedures, one for each type of service provider. The between-subjects factors were professional role (i.e., directors versus supervisors) and type of credential held (teaching only vs. student support), the within-subjects factor was type of mental health service (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). To protect against inflation of the Type I error

rate, a Bonferroni adjustment was used and each ANOVA was tested at an alpha level of .0167. The Huynh-Feldt test was used to determine statistical significance for within-subjects effects, as the sphericity assumption was violated.

School Psychologists. Examination of Table 15 reveals that for the within-subjects effects, the Service x Role x Credential interaction was not statistically significant, $F (5, 380) = .40$, $p > .05$. Similarly, neither of the two-way interaction effects was statistically significant, Service x Credential, $F (5, 380) = 1.75$, $p > .05$, and Service x Role, $F (5, 380) = 1.04$, $p > .05$. The main effect for type of mental health service, however, was statistically significant, $F (5, 380) = 16.87$, $p < .001$.

For the between-subjects effects, the Role x Credential interaction was not statistically significant, $F (1, 74) = .06$, $p > .05$, neither was the main effect for professional role, $F (1, 74) = 0.92$, $p > .05$. The main effect for type of credential, was however, statistically significant, $F (1, 74) = 9.45$, $p < .05$. Thus, as is shown in Table 16, regardless of professional role (director vs. supervisor), those respondents who held a teaching only credential rated school psychologists as significantly more qualified to provide mental health services (M=4.22) than did their counterparts who held a student services support credential (M=4.09).

Table 15

*Analysis of Variance of Ratings of Perceived Qualifications of **School Psychologists** to Provide MH Services by Professional Role and Type of Credential*

Source	df	SS	MS	F	H-F
Between Ss					
Role (A)	1	1.73	1.73	0.92	
Credential (B)	1	17.87	17.87	9.45*	
Role*Credential	1	0.11	0.11	0.06	
S/AB (error)	76	143.71	1.89		
Within Ss					
Service (C)	5	49.79	9.96	16.87	< .001*
Service*Role (AC)	5	3.07	0.62	1.04	ns
Service*Credential (BC)	5	5.15	1.03	1.75	ns
Service*Role*Credential (ABC)	5	1.19	0.24	0.40	ns
SC/AB (error)	380	224.28	0.59		
Total	479	446.84			

*p<.0167

Note: Professional Role (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

Table 16

*Means of Ratings of Perceived Level of Qualifications of **School Psychologists** to Provide MH Services by Professional Role and Type of Credential*

	Type of Credential		
	Teaching Only	Student Support	Marginal Mean
MH Service	M	M	M
	Directors		
Counseling	4.53	4.16	
Consultation	4.53	4.71	
Normative Assessment	4.98	4.97	
Authentic Assessment	4.55	4.64	
Prevention	4.06	3.94	
Intervention	4.06	3.86	
Marginal Mean	4.45	4.38	4.42
	Supervisors		
Counseling	4.03	3.37	
Consultation	4.30	4.13	
Normative Assessment	4.78	4.91	
Authentic Assessment	3.81	3.44	
Prevention	3.36	3.29	
Intervention	3.64	3.71	
Marginal Mean	3.99	3.80	3.90
Overall MH Services	4.22	4.09	4.15

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Professional Role: (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

Service Main Effect. To determine the mental health services between which there were significant differences in mean ratings for school psychologists as perceived by directors and supervisors combined, Tukey's HSD post hoc test was employed. Results of these analyses revealed that across directors and supervisors, the mean qualification rating for normative assessment was significantly higher than ratings for counseling, authentic assessment, prevention, and intervention services (see Table 17). In addition, the qualification mean rating to provide services in consultation was significantly higher than ratings for counseling, authentic assessment, prevention, and intervention. No significant differences were observed in ratings between counseling, authentic assessment, prevention and intervention. Thus school psychologists were considered by the directors and supervisors to be significantly better qualified to provide mental health services in the areas of normative assessment and consultation (M=4.89 and 4.29, respectively) than in counseling, authentic assessment, prevention, and intervention where they were considered to be somewhat qualified to provide these services with some supervision needed.

Table 17

*Means and Standard Deviations of Ratings of Qualifications of **School Psychologists** to Provide MH Services to Directors and Supervisors Combined*

	School Psychologist	
MH Service	M	SD
Counseling	3.87	1.03
Consultation	4.29	0.60
Normative Assessment	4.89	0.24
Authentic Assessment	3.84	1.12
Prevention	3.52	0.87
Intervention	3.78	0.82

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

School Counselors. Examination of Table 18 reveals that for the within-subjects effects the Service x Role x Credential interaction was not statistically significant, $F (5, 390) = 1.28$, $p > .05$, nor were the interaction effects for Service x Credential, $F (5, 390) = 1.75$, $p > .05$ and Service x Role, $F (5, 390) = 0.74$, $p > .05$. However, there was a statistically significant main effect for type of mental health service, $F (5, 390) = 28.85$, $p < .001$.

The between-subjects effects were not statistically significant, the Role x Credential interaction, $F (1, 78) = .031$, $p > .05$, the credential main effect, $F (1, 78) = 2.72$, $p > .05$ and role main effect, $F (1, 78) = 0.61$, $p > .05$.

Table 18

*Analysis of Variance of Ratings of Perceived Qualifications of **School Counselors** to Provide MH Services by Professional Role and Type of Credential*

Source	df	SS	MS	F	H-F
Between Ss					
Role (A)	1	1.05	1.05	0.61	
Credential (B)	1	4.68	4.68	2.72	
Role*Credential	1	0.52	0.52	0.31	
S/AB (error)	78	134.27	1.72		
Within Ss					
Service (C)	5	79.76	15.95	28.85	<.001*
Service*Role (AC)	5	2.06	0.41	0.74	ns
Service*Credential (BC)	5	4.84	0.97	1.75	ns
Service*Role*Credential (ABC)	5	3.53	0.71	1.28	ns
SC/AB (error)	390	242.86	0.53		
Total	491	473.57			

*p<.0167
Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified
Professional Role: (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

Service Main Effect. To determine the mental health services between which there were significant differences in mean ratings for school counselors (as perceived by directors and supervisors, combined) Tukey's HSD post hoc test was employed. Results of these analyses revealed across directors and supervisors, the mean ratings of perceived qualifications of school counselors to provide services in consultation were significantly higher ($p<.05$) than ratings for normative assessment no significant differences in

qualification ratings were observed between consultation, and counseling, normative assessment, authentic assessment, prevention, and intervention (see Table 19).

Table 19

*Mean and Standard Deviation of Perceived Qualifications of **School Counselors** to Provide MH Services*

	School Counselors	
MH Service	M	SD
Counseling	3.90	0.83
Consultation	4.06	0.62
Normative Assessment	3.64	0.58
Authentic Assessment	3.78	1.08
Prevention	3.68	0.69
Intervention	3.83	0.83

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

School Social Workers. Examination of the data in Table 20 reveals that for the within-subjects effects, statistical significance was observed for the main effect for type of mental health service, $F (5, 320) = 38.41$, $p < .001$. The Service x Role x Credential, $F (5, 320) = 0.92$, $p > .05$, Service x Credential interaction, $F (5, 320) = 0.51$, $p > .05$ and Service x Role interaction, $F (5, 320) = 0.63$, $p > .05$ effects were not statistically significant. No statistical significance was found for the between-subjects effects.

Table 20

*Analysis of Variance of Ratings of **School Social Workers** Based on Perceptions of Their Qualifications to Provide MH Services by Professional Role and Type of Credential*

Source	df	SS	MS	F	H-F
Between Ss					
Role (A)	1	0.09	0.09	0.03	
Credential (B)	1	3.20	3.20	1.08	
A*B	1	9.43	9.43	3.17	
S/AB (error)	64	190.05	2.97		
Within Ss					
MH Service (C)	5	96.13	19.22	38.41	<.001*
MH Service*Role (CA)	5	1.57	0.31	0.63	ns
MH Service*Credential (CB)	5	1.28	0.26	0.51	ns
MH Service*Role*Credential (CAB)	5	2.31	0.46	0.92	ns
SC/AB (error)	320	160.17	0.50		
Total	407	464.23			

*p<.0167

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Professional Role: (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

Service Main Effect. To determine the mental health services between which there were significant differences in overall mean ratings for school social workers across directors and supervisors, Tukey's HSD post hoc test was employed. Results of these analyses revealed that mean ratings of perceived qualifications of school social workers to provide services in counseling was significantly higher than ratings for authentic assessment and intervention but not for the other mental health services, consultation, normative assessment, and prevention. Ratings for consultation were significantly higher

than ratings for authentic assessment and intervention but not for normative assessment and prevention. The ratings for normative assessment were significantly higher than that for authentic assessment but not for prevention and intervention. No differences in ratings were observed between prevention and intervention (see Table 21).

Table 21

*Mean and Standard Deviation of Perceived Qualifications of **School Social Workers** to Provide MH Services*

	School Social Workers	
MH Service	M	SD
Counseling	4.09	0.83
Consultation	3.96	0.75
Normative Assessment	3.65	0.68
Authentic Assessment	3.11	1.01
Prevention	3.77	0.71
Intervention	3.47	1.02

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

In sum, although there were overall differences in the ratings of qualifications of *school psychologists* by type of credential held, the type of credential held did not moderate the perceptions of directors versus supervisors and the perceived level of qualification of the three service providers (school psychologists, counselors, and social workers) to provide mental health services to students and their families.

Research Question Four: To What Extent do Student Services Directors and Supervisors Differ in their Perceptions of the Impact of Mental Health Services on Students' Academic and Behavioral Outcomes

The fourth research question assessed directors' and supervisors' perceptions of the impact of specified mental health services (i.e., counseling, consultation, normative assessment, authentic assessment, intervention, prevention) on students' academic and behavioral outcomes and whether this differed by professional role of the rater (directors vs. supervisors). The ratings were based on a 5-point Likert-type scale (5= Very strong impact; 4= Strong impact; 3= Fairly strong impact; 2= Minimal impact; 1= No impact).

Means and standard deviations of ratings of the perceived level of impact of the mental health services on student academic and behavioral outcomes by student services directors and supervisors as a combined group and by individual groups were computed. Data were subjected to analysis of variance procedures to determine if there were significant differences in perceptions between directors and supervisors.

Academic Outcomes. Mean ratings of the perceived level of impact of the mental health services (counseling, consultation, normative assessment, authentic assessment, prevention, and other) on student *academic* outcomes as perceived by student services directors and all supervisors combined are reported in Table 22 and by directors and individual service providers in Table 23.

Table 22

*Ratings of Perceived Impact of Mental Health Services on **Academic Outcomes** by Directors and Supervisors*

	Directors Student Services		Supervisors	
MH Services	M	SD	M	SD
Counseling	3.83	0.99	3.94	1.03
Consultation	4.00	0.87	3.68	0.88
Normative Assessment	3.38	1.04	3.17	1.11
Authentic Assessment	4.08	1.09	3.40	1.42
Prevention	3.77	0.78	3.34	0.70
Intervention	3.72	0.82	3.35	0.78
Other	3.46	1.18	3.11	0.98
Overall Mental Health Services	3.74	0.97	3.43	0.99

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Professional Role (Directors vs. Supervisors)

Table 23

*Ratings of Perceived Impact of Mental Health Services on **Academic Outcomes** by Professional Position*

	Directors Student Services		Supervisors Psychology		Supervisors School Counseling		Supervisors Social Work	
MH Services	M	SD	M	SD	M	SD	M	SD
Counseling	3.83	0.99	3.69	1.00	3.84	1.21	4.58	0.49
Consultation	4.00	0.87	3.51	0.92	3.77	0.75	4.02	0.91
Normative Assessment	3.38	1.04	3.05	1.16	3.02	1.27	3.67	0.72
Authentic Assessment	4.08	1.09	3.66	1.31	2.83	1.72	3.78	1.09
Prevention	3.77	0.78	3.19	0.70	3.34	0.68	3.74	0.72
Intervention	3.72	0.82	3.19	0.69	3.47	0.91	3.64	0.83
Other	3.46	1.18	3.02	0.90	2.90	1.10	3.71	0.86
Range of Ratings	3.38-4.08		3.02-3.69		2.83-3.84		3.64-4.58	

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Professional Position (Directors vs. Supervisors of Psychology, School Counseling and Social Work)

Examination of Table 22 reveals that directors rated consultation (M= 4.00) and authentic assessment (M= 4.08) as the two mental health services which have a strong impact on academic outcomes. In contrast, supervisors, as a combined group, rated all mental health services as having a fairly strong impact, in general, on academic outcomes with counseling and consultation as the services that have the stronger impact.

When the supervisors are partitioned by their individual roles (see Table 23), supervisors of psychology were found to rate all mental health services as having a fairly strong impact on academic outcomes. Supervisors of guidance and counseling rated all mental health services, except authentic assessment and "Other" services as having a fairly strong impact on academic outcomes. "Other" services (M=2.90) and authentic assessments (M=2.83) were rated by supervisors of guidance and counseling as having a minimal impact on academic outcomes. Finally, supervisors of social work rated counseling and consultation (M= 4.58 and 4.02, respectively) as having a strong impact on academic outcomes, while all other mental health services were rated as having a fairly strong impact on academic outcomes.

Test of Differences in Perceptions between Directors and Student Services Supervisors. To determine if directors and supervisors differed in their perceptions of the impact of mental health services on student academic outcomes, data were subjected to a one between- one-within subjects analysis of variance (ANOVA) procedure. The between-subjects factor was professional role (i.e., student services directors versus supervisors) and the within-subjects factor was type of mental health service (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). As was done in previous analyses, the "Other" category was not included

in these analyses as it covered a range of services not clearly delineated. The ANOVA was tested at an alpha level of .05. The Huynh-Feldt test was used to determine statistical significance for within-subjects factors, as the sphericity assumption was violated.

Examination of Table 24 reveals no statistically significant interaction effect for Service x Role, $F (5, 415) = 2.38$, $p > .05$, however, a significant main effect was observed for type of mental health service, $F (5, 415) = 6.08$, $p < .001$, employing the Huynh-Feldt adjustment. For the between-subjects effects, the main effect for type of professional role was not statistically significant, $F (1, 83) = 3.08$, $p > .05$.

Thus, the data suggest that there were no significant differences in perceptions about the impact of mental health services on academic outcomes between student services directors and supervisors. However, a main effect for type of mental health service was significant; it was observed that supervisors and directors combined, rated specific mental health services as having a significantly greater impact on student academic outcomes than other services.

Table 24

*Analysis of Variance of Perceived Qualifications about the Impact of Mental Health Services on **Academic Outcomes** by Professional Role*

Source	df	SS	MS	F	
Between Ss					
Role (A)	1	8.96	8.96	3.08	
S/AB (error)	83	241.43	2.91		
Within Ss					
MH Service (B)	5	17.88	3.58	6.08	<.001*
MH Service*Role (BA)	5	6.99	1.39	2.38	ns
SC/AB (error)	415	243.99	0.59		
Total	509	519.25			

*p<.05
Note: Professional Role (Directors vs. Supervisors)

Service Main Effect. To determine the mental health services between which there were significant mean differences in ratings by directors and supervisors (see Table 25), Tukey's HSD post hoc test was employed. Results of these analyses revealed student services directors and supervisors rated counseling services as having a significantly stronger impact on student academic outcomes ($p<.05$) than normative assessment, authentic assessment, prevention, and intervention services. Mean ratings for consultation were significantly higher than that for normative assessment, prevention and intervention services. In addition, mean ratings for normative assessment were significantly higher than that for authentic assessment. No significant differences in ratings of impact on academic outcomes were observed between prevention and intervention.

Table 25

*Mean and Standard Deviation of Ratings of Perceived Impact of Mental Health Services on **Academic Outcomes***

MH Service	M	SD
Counseling	3.91	1.02
Consultation	3.77	0.88
Normative Assessment	3.23	1.09
Authentic Assessment	3.60	1.36
Prevention	3.47	0.75
Intervention	3.46	0.81

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Behavioral Outcomes. The mean ratings of the perceived level of impact of the mental health services (counseling, consultation, normative assessment, authentic assessment, prevention, and other) on student *behavioral* outcomes as perceived by student services directors and all supervisors combined are reported in Tables 26 and by directors and individual service providers in Table 27.

Data reported in Table 26 reveal that both directors and supervisors rate counseling as having a strong impact on behavioral outcomes. Supervisors' rated authentic and normative assessments as having a minimal impact on behavioral outcomes. Thus, directors and supervisors rated the impact of mental health services on behavioral outcomes as having a strong to minimal impact.

Table 26

*Ratings of Perceived Impact of Mental Health Services on **Behavioral Outcomes** by Directors and Supervisors*

	Directors Student Services		Supervisors	
MH Services	M	SD	M	SD
Counseling	4.13	0.86	4.28	0.93
Consultation	4.08	0.90	3.84	0.96
Normative Assessment	3.34	1.08	2.95	1.04
Authentic Assessment	2.88	1.18	2.58	1.07
Prevention	3.96	0.70	3.63	0.78
Intervention	4.08	0.80	3.93	0.70
Other	3.74	1.14	3.58	0.89
Overall Mental Health Services	3.74	0.95	3.54	0.91

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Professional Role (Directors vs. Supervisors)

Table 27

*Ratings of Perceived Impact of Mental Health Services on **Behavioral Outcomes** by Professional Position*

	Directors Student Services		Supervisors Psychology		Supervisors School Counseling		Supervisors Social Work	
MH Services	M	SD	M	SD	M	SD	M	SD
Counseling	4.13	0.86	4.00	0.97	4.34	1.04	4.77	0.42
Consultation	4.08	0.90	3.71	0.95	3.84	0.97	4.19	0.93
Normative Assessment	3.34	1.08	2.76	0.99	2.82	1.21	3.55	0.81
Authentic Assessment	2.88	1.18	2.64	0.88	2.17	1.22	3.19	1.81
Prevention	3.96	0.70	3.43	0.89	3.68	0.62	4.03	0.68
Intervention	4.08	0.80	3.84	0.81	4.03	0.68	4.11	0.58
Other	3.74	1.14	3.52	0.91	3.43	0.90	4.01	0.81
Range of Ratings	2.88-4.13		2.64-4.00		2.17-4.34		3.19-4.77	

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Professional Position (Directors vs. Supervisors of Psychology, School Counseling and Social Work)

When the professionals are partitioned by their individual roles (see Table 27), directors rated counseling (M= 4.13), intervention (M= 4.08), and consultation (M= 4.08) as having a strong impact on behavioral outcomes, while authentic assessment (M= 2.88) was rated as having a minimal impact. In contrast, directors perceived prevention (M= 3.96), "Other" services (M= 3.74) and normative assessment (M= 3.34) as having a fairly strong impact on behavioral outcomes. Supervisors of psychology rated only counseling (M=4.00) as having a strong impact on behavioral outcomes and normative (M= 2.76) and authentic (M=2.64) assessments as having a minimal impact on behavioral outcomes. They rated mental health services such as, intervention (M=3.84), consultation (M=3.71), "Other" services (M=3.52), and prevention (M=3.43) were all rated as having a fairly strong impact on behavioral outcomes. Supervisors of guidance and counseling rated counseling and intervention (M=4.34 and 4.03, respectively) as having a strong impact on behavioral outcomes and consultation (M=3.84) and "Other" services (M=3.43) as having a fairly strong impact, they rated both normative (M= 2.82) and authentic (M= 2.17) assessments as having a minimal impact on behavioral outcomes. Finally, supervisors of social work rated all mental health services except normative and authentic assessment as having a strong impact on behavioral outcomes. They rated normative (M=3.55) and authentic (M=3.19) assessments as having a fairly strong impact on behavioral outcomes. Thus, Table 27 reveals a pattern which indicates that counseling and intervention are perceived to have a strong impact on behavioral outcomes, while normative and authentic assessments are perceived to have minimal impact on behavioral outcomes.

Test of Differences in Perceptions between Directors and Student Services Supervisors. To determine whether directors and supervisors differed in their perceptions of the impact of mental health services on student behavioral outcomes, data were subjected to a one between- one within analysis of variance (ANOVA) procedure. The between-subjects factor was professional role (i.e., student services directors versus supervisors) and the within-subjects factor was type of mental health service (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). As in the previous analyses, the "Other" category was not included in these analyses as it covered a range of services not clearly delineated. The ANOVA was tested at an alpha level of .05. The Huynh-Feldt test was used to determine statistical significance for within-subjects factor, as the sphericity assumption was violated.

Examination of Table 30 reveals no statistically significant interaction effects for Service x Role, $F (5, 410) = 1.50$, $p > .05$; however, a significant main effect was observed for type of mental health service, $F (5, 410) = 54.74$, $p < .001$. For the between-subjects effects, type of professional role was not statistically significant, $F (1, 82) = 1.17$, $p > .05$.

Thus, data suggest there were no significant differences in perceptions about the impact of mental health services on behavioral outcomes between student services directors and supervisors. However, a main effect for type of mental health service was significant. It was observed that supervisors and directors combined, rated specific mental health services as having a significantly stronger impact on student behavioral outcomes than other services.

Table 28

*Analysis of Variance of Perceived Qualifications about the Impact of Mental Health Services on **Behavioral Outcomes** by Professional Role*

Source	df	SS	MS	F	
Between Ss					
Role (A)	1	3.38	3.38	1.17	
S/AB (error)	82	237.62	2.90		
Within Ss					
MH Service (B)	5	117.95	23.59	54.74	<.001*
MH Service*Role (BA)	5	3.23	0.65	1.50	ns
SC/AB (error)	410	176.69	0.43		
Total	503	538.87			

*p<.05
Note: Professional Role (Directors vs. Supervisors)

Service Main Effect. To determine differences in mean ratings of mental health services by directors and supervisors for behavioral outcomes, Tukey's HSD post hoc test was employed. Results of these analyses revealed that supervisors and directors combined rated counseling as having a significantly stronger impact on behavioral outcomes (p<.05) than consultation, normative assessment, authentic assessment, and prevention. Consultation was rated as having a significantly stronger impact on behavioral outcomes than normative assessment, authentic assessment, and prevention. There were no significant differences in impact for consultation and intervention. Finally, normative assessment was rated as having a significantly stronger impact on behavioral outcomes than authentic assessment. Thus, supervisors and directors rated counseling as having the stronger impact on student behavioral outcomes.

Table 29

*Mean and Standard Deviation of Ratings of Perceived Impact of Mental Health Services on **Behavioral Outcomes***

MH Service	M	SD
Counseling	4.23	0.92
Consultation	3.91	0.94
Normative Assessment	3.06	1.06
Authentic Assessment	2.67	1.11
Prevention	3.72	0.77
Intervention	3.97	0.73

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Research Question 5: Perceived Impact of Mental Health Services on Students' Academic and Behavioral Outcomes by Professional Role and Type of Credential Held.

The fifth research question sought to determine the extent to which the credential held by student services directors and supervisors moderated their beliefs regarding the impact of mental health services on academic and behavioral outcomes of students. The ratings were based on a 5-point Likert-type scale (5= Very strong impact; 4= Strong impact; 3= Fairly strong impact; 2= Minimal impact; 1= No impact).

To determine if there were significant differences in the ratings of impact of mental health services on academic and behavioral outcomes from the perspective of directors and supervisors by type of credential held, two separate two between- one within-subjects analysis of variance (ANOVA) procedures were conducted. The between-subjects factors were professional role (i.e., directors versus supervisors) and type of

credential (teaching only vs. student support) and the within-subjects factor was type of mental health service (i.e., counseling, consultation, normative assessment, authentic assessment, prevention, and intervention). The ANOVA was tested at the alpha level of .05. The Huynh-Feldt test was used to determine statistical significance for within-subjects effects, as the sphericity assumption was violated.

Academic Outcomes. A breakdown of mean ratings by professional role (directors vs. supervisors), type of credential (teaching only vs. student support) and type of service (counseling, consultation, normative assessment, authentic assessment, prevention, and intervention) is reported in Table 30.

Summary data for the two between- one-within-subjects ANOVA for perceived impact on academic outcomes are reported in Table 31. Examination of this table revealed the interaction effects for Service x Role x Credential, $F (5, 395) = 0.26$, $p > .05$, Service x Credential, $F (5, 395) = 0.86$, $p > .05$, and Service x Role, $F (5, 395) = 1.23$, $p > .05$ were not significant. The main effect for Service was also not statistically significant, $F (5, 395) = 2.20$, $p > .05$.

For the between-subjects factors the Role x Credential interaction effect was statistically significant, $F (1, 79) = 5.62$, $p < .05$; however, the main effects for type of Credential held, $F (1, 79) = 0.93$, $p > .05$, and type of professional Role, $F (1, 79) = 4.97$, $p > .05$, were not significant.

Table 30
*Means of Ratings of Perceived Impact of Mental Health Services on **Academic Outcomes** by Role and Type of Credential*

	Type of Credential		
	Teaching Only	Student Support	Marginal Mean
MH Service	M	M	M
	Directors		
Counseling	4.07	3.38	
Consultation	4.27	3.21	
Normative Assessment	3.88	3.16	
Authentic Assessment	4.55	3.19	
Prevention	4.19	3.35	
Intervention	4.04	3.39	
Marginal Mean	4.16	3.28	3.72
	Supervisors		
Counseling	3.59	4.03	
Consultation	3.74	3.75	
Normative Assessment	3.13	3.17	
Authentic Assessment	3.73	3.43	
Prevention	3.78	3.34	
Intervention	3.46	3.36	
Marginal Mean	3.57	3.51	3.54
Overall MH Services	3.87	3.39	3.63

Note: Response Scale:
5: highly qualified; no supervision needed
4: qualified; minimal supervision needed
3: somewhat qualified; supervision is needed
2: minimally qualified; intense supervision needed
1: Not qualified

Professional Role: (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

Table 31

*Analysis of Variance of Perceived Qualifications about the Impact of Mental Health Services on **Academic Outcomes** by Professional Role and Type of Credential*

Source	df	SS	MS	F	
Between Ss					
Role (A)	1	14.07	14.07	4.97	
Credential (B)	1	2.62	2.62	0.93	
Role*Credential (A*B)	1	20.53	20.53	5.62*	
S/AB (error)	79	223.60	2.83		
Within Ss					
MH Service (C)	5	6.56	1.31	2.20	ns
MH Service*Role (CA)	5	3.65	0.73	1.23	ns
MH Service*Credential (CB)	5	2.57	0.51	0.86	ns
MH Service*Role*Credential (CAB)	5	0.78	1.56	0.26	ns
SC/AB (error)	395	235.41	0.59		
Total	497	509.79			

*p<.025

Note: Professional Role (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

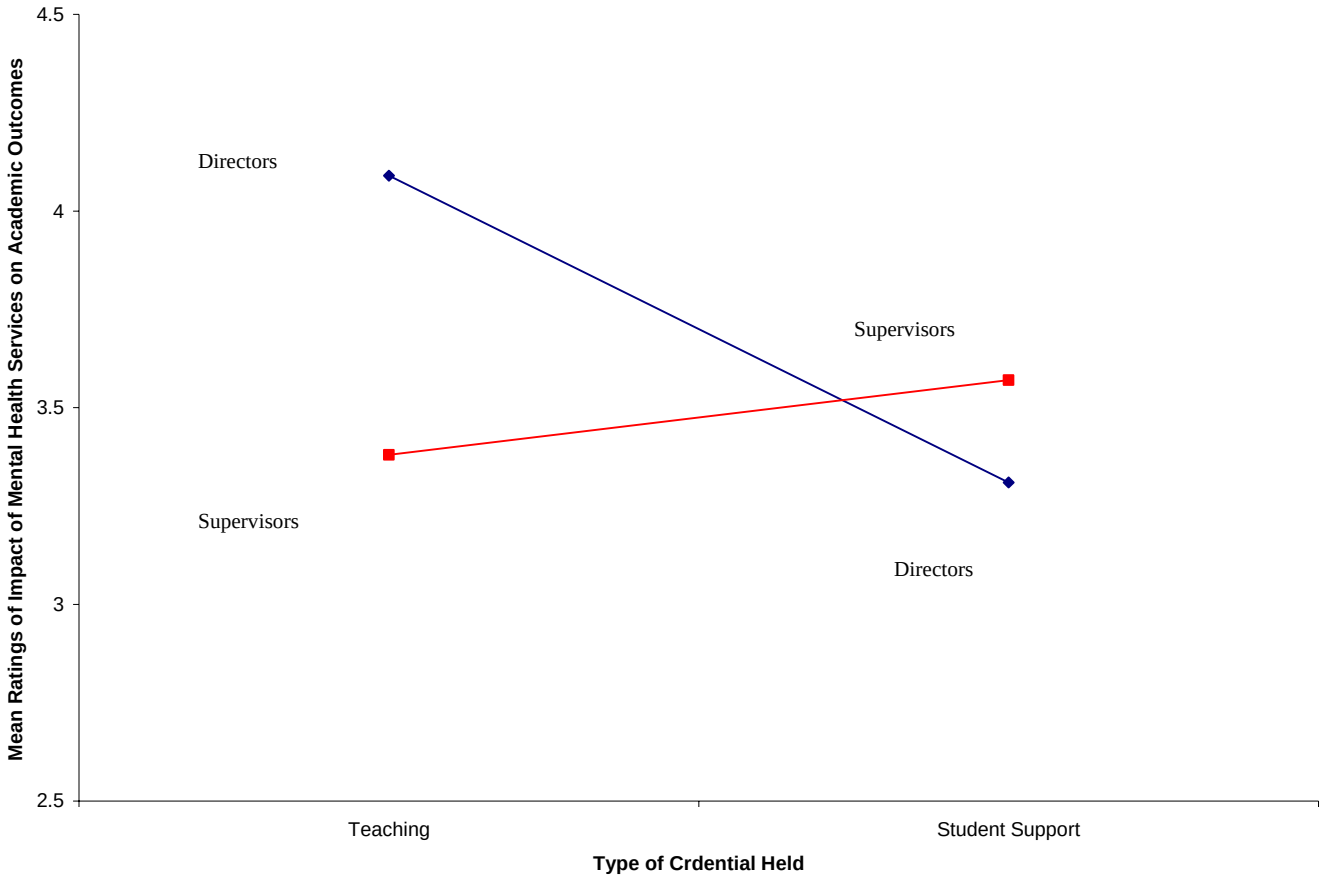
Role x Credential Interaction. To determine whether the type of credential held influenced the ratings of directors and supervisors about the impact of mental health services on academic outcomes, post hoc analyses were conducted using Dunn's test. A graph of the interaction effect is shown in Figure 4.

Results of these analyses reveal that for respondents who had a teaching only credential, there was a significant difference ($p < .05$) in mean ratings of impact on academic outcomes between directors and supervisors. More specifically, directors who had a teaching only credential rated mental health services, overall, as having a stronger impact on academic outcomes ($M = 4.09$) than supervisors with a teaching only credential ($M = 3.38$). There were no significant differences in the ratings of supervisors and directors with a student support credential.

Consequently, type of credential held moderated the beliefs of directors and supervisors relative to the degree of impact of mental health services on student academic outcomes.

Figure 5

Role by Credential Interaction Effect of Impact of Overall Mental Health Services on Academic Outcomes



Behavioral Outcomes. A breakdown of mean ratings by professional role (directors vs. supervisors), type of credential (teaching only vs. student support) and type of service (counseling, consultation, normative assessment, authentic assessment, prevention, and intervention) is reported in Table 32.

Table 33 provides summary data for the two between- one-within-subjects ANOVA for perceived impact of mental health services on behavioral outcomes as a function of professional role and type of credential held. As is shown, the main effect for type of service is statistically significant, $F (5, 390) = 30.74$, $p < .001$. However, none of the interaction effects associated with the within-subjects factors is significant

For the between-subjects factors, the Role x Credential interaction effect is statistically significant, $F (1, 78) = 5.51$, $p < .05$; the main effects for type of credential held, $F (1, 78) = 0.71$, $p > .05$ and professional role, $F (1, 78) = 2.75$, $p > .05$, were not significant.

Table 32

*Means of Ratings of Perceived Impact of Mental Health Services on **Behavioral Outcomes** by Role and Type of Credential*

	Type of Credential		
	Teaching Only	Student Support	Marginal Mean
MH Service	M	M	M
	Directors		
Counseling	4.25	3.63	
Consultation	4.33	3.50	
Normative Assessment	3.88	2.91	
Authentic Assessment	3.55	2.63	
Prevention	4.20	3.49	
Intervention	4.34	3.73	
Marginal Mean	4.09	3.31	3.70
	Supervisors		
Counseling	3.97	4.37	
Consultation	3.30	3.90	
Normative Assessment	3.13	2.96	
Authentic Assessment	2.35	2.58	
Prevention	3.78	3.65	
Intervention	3.77	3.96	
Marginal Mean	3.38	3.57	3.48
Overall MH Services	3.74	3.44	3.59

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Professional Role (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

Table 33

*Analysis of Variance of Perceived Qualifications about the Impact of Mental Health Services on **Behavioral Outcomes** by Professional Role and Type of Credential*

Source	df	SS	MS	F	H-F
Between Ss					
Role (A)	1	7.77	7.77	2.75	
Credential (B)	1	1.99	1.99	0.71	
Role*Credential (A*B)	1	15.55	15.55	5.51*	
S/AB (error)	78	220.24	2.82		
Within Ss					
MH Service (C)	5	64.22	12.84	30.74*	< .001
MH Service*Role (CA)	5	1.59	0.31	0.77	ns
MH Service*Credential (CB)	5	5.45	1.09	2.61	ns
MH Service*Role*Credential (CAB)	5	0.56	0.11	0.27	ns
SC/AB (error)	390	162.95	0.42		
Total	491	480.32			

*p<.05
Note: Professional Role (Directors vs. Supervisors); Credential (Teaching only vs. Student Support)

Service Main Effect. To determine the mental health services between which overall mean ratings for directors and supervisors combined, were statistically significant, Tukey's HSD post hoc test was employed (alpha level= .05). Results of these analyses revealed that mean ratings of directors and supervisors on the perceived impact of counseling on behavioral outcomes was significantly stronger ($p < .05$) than that of consultation, normative assessment, authentic assessment, and prevention. In addition, directors and supervisors rated services in consultation as having a significantly stronger impact on behavioral outcomes than normative assessment, authentic assessment, and prevention. The ratings for normative assessment were rated as having a significantly stronger impact on behavioral outcomes than authentic assessment.

Role x Credential Interaction. To interpret the significant of role by credential interaction effect, Dunn's post hoc test (alpha level= .05) was employed. A graph of the disordinal interaction effect is shown in Figure 6 and relevant cell means are reported in Table 32.

Results of Dunn's test reveal that in the case of respondents who had a teaching only credential, there was a significant difference between the mean ratings of directors and supervisors. Directors who had a teaching only credential were found to rate mental health services as having a stronger impact on behavior outcomes (M=4.09) than supervisors with a teaching only credential (see Table 32). There were no significant differences in the mean ratings of supervisors and directors who held a student support credential (M=3.31 and 3.57, respectively).

Consequently, the type of credential held moderated the beliefs of directors and supervisors relative to the degree of impact of mental health services on student behavior outcomes. More specifically, differences existed between individuals with a teaching only credential while no differences existed between those with a student support credential.

Table 34

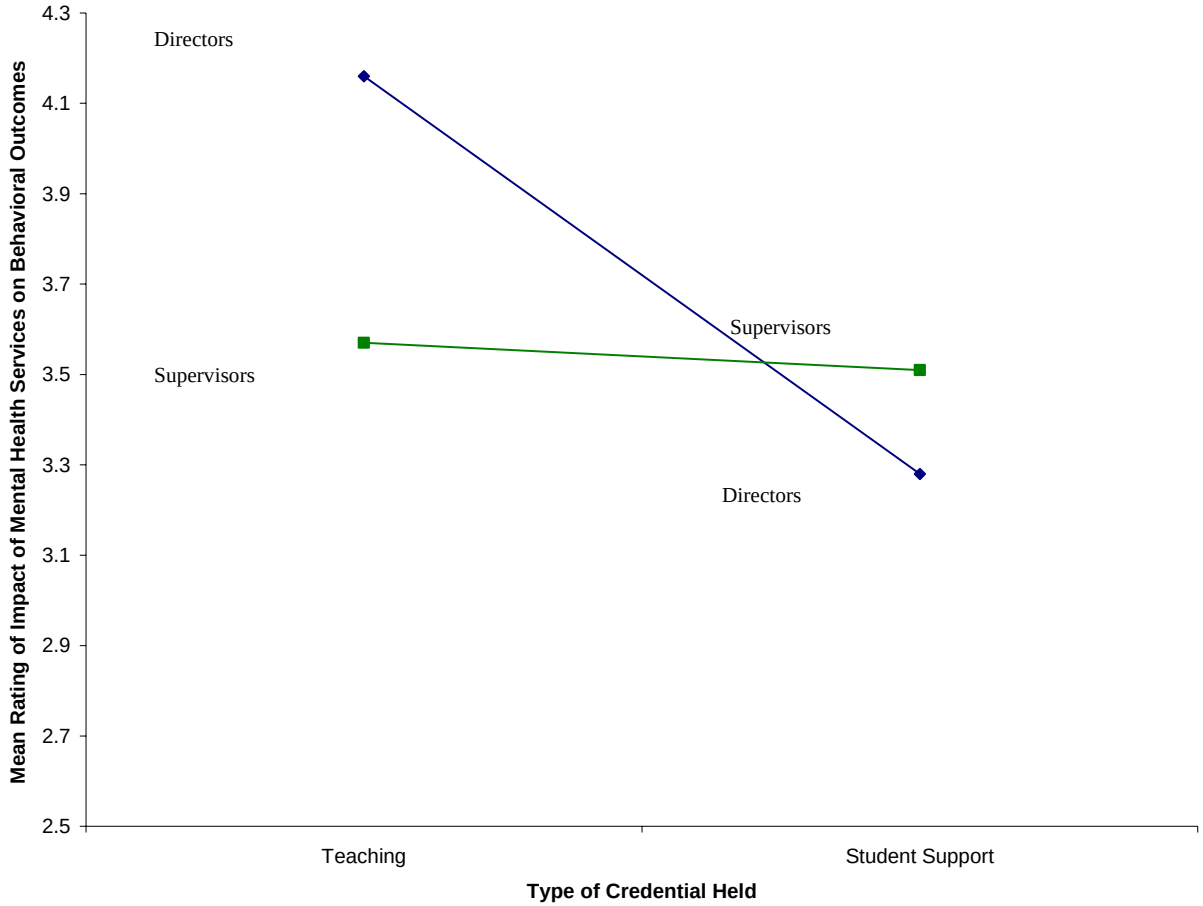
*Mean and Standard Deviation of Ratings of Perceived Impact of Mental Health Services on **Behavioral Outcomes***

MH Service	M	SD
Counseling	4.23	0.92
Consultation	3.91	0.94
Normative Assessment	3.06	1.06
Authentic Assessment	2.67	1.11
Prevention	3.72	0.77
Intervention	3.97	0.73

Note: Response Scale:
5= Very strong impact
4= Strong impact
3= Fairly strong impact
2= Minimal impact
1= No impact

Figure 6

Role by Credential Interaction Effect of Impact of Overall Mental Health Services on Behavioral Outcomes



Chapter Five

Summary, Discussion, Implications, and Recommendations for Future Research

Educational reforms which are high-stakes and accountability-driven have brought a renewed sense of urgency to assist students with and without disabilities to achieve better outcomes (Bradley, Henderson, & Monfore, 2004). Schools are expected to provide a range of general, special, and alternative education programs which will meet the needs of diverse learners, including those with significant mental health problems (U.S. Dept. of Education, 2001). Mental health service providers, such as school psychologists, school counselors, and school social workers provide services that are necessary for the educational success of diverse learners. However, research has shown that it is the beliefs of district and state school administrators that actually determine the mental health services which are valued and provided in public school settings (Leadership Training: Continuing Education for Change, 2003).

The purpose of this study was to examine the types of mental health services provided to students in school districts in Florida and the extent to which those services were provided. In addition, the study investigated the beliefs of student services directors and supervisors about the qualifications of school mental health service providers to provide mental health services and their beliefs about the impact of mental health services on academic and behavioral outcomes.

The participants in this study were student services directors and supervisors of psychological services, school social work, and guidance and counseling employed throughout the 67 school districts in Florida. For the purpose of this study, the participants were asked to complete *The Perception of School Mental Health Services* (PSMHS) Survey (Versions A and B; see appendices A & B). The PSMHS Survey (Dixon, 2006) was designed to gather data on demographic information of student services directors and supervisors of student services (e.g., highest degree earned, years of experience in current position), district demographic information (e.g., size of school district), the types of mental health services offered in the district (e.g., individual counseling, consultation, authentic assessment) and perceptions of the level of qualification of school psychologists, school counselors, and/or school social workers to provide a number of different mental health services. In addition, data were collected on the perceptions of administrators regarding which mental health services were related directly to student outcomes.

Summary and Discussion of Findings

Demographic Characteristics

This study was exploratory in nature due to the limited literature base regarding the relationship between administrator beliefs about school-based mental health services, school mental health providers' qualifications to provide such services, and the link between mental health services and student outcomes. Based on the demographic information that was obtained from this study, it can be concluded that the sample of student services directors had most often earned a degree in administration and special education and they were somewhat split between teaching only and student support

services credentials. In contrast, student services supervisors earned degrees in a number of areas, which reflected the diversity of their roles and training for their specific credential. Student services supervisors earned degrees in the area of psychology, counseling, social work and administration and were most likely to have a student support services credential. Clearly, there were differences between directors and supervisors in their training and degree/certification areas. Directors had either teaching or administrative preparation whereas supervisors had degrees in specific mental health service delivery areas. Thus, it may be plausible that this difference in preparation might account for differences in perceptions.

The majority of student services directors in the sample had been in the field of education for more than 15 years and more than 50% were appointed to their current position in the last 1 to 5 years. The majority of student services supervisors had been in the field of education for over 15 years and 44% reported being in their current position as a supervisor for over 11 years. This is of significance, because the length of time in the field may have influenced their understanding and acceptance of the many changes in the mental health field and education which support the expansion of the mental health service provider roles.

The data collected about the school districts revealed interesting results in both the large and small districts in Florida. Larger districts served higher numbers of minority students, students who were emotionally handicapped/or with severe emotional disturbances, and they had high rates of students that were suspended. Smaller districts, however, served higher numbers of students from low-income households and also high rates of students who were suspended. These results are congruent with the research on

school suspension, which suggests that schools often have higher rates of suspension when serving students who are in greatest academic, emotional, and economic need (i.e., high rates of poverty or minority populations). Rather than finding services which promote the behavior change that these students need, suspension usually places them in unsafe settings or settings which are restrictive and do not address their mental health needs (Atkins, et. al, 2002).

In order for school districts to provide students with effective mental health services, resources, time, and staff must be available. The professional associations representing school psychologists, school counselors, and school social workers have recommended staff to student ratios to ensure the effectiveness of service delivery (Curtis, Grier, Abshier, Sutton, & Hunley, 2002; Kestenbaum, 2000; Franklin, 2000). In this study, the school personnel to student ratio by district size for school psychologists and social workers were often over the recommended ratios. This is not surprising as Curtis, Grier, & Hunley, 2004 noted that the exiting of school psychologists from the field due to retirement and attrition resulted in a projected shortage of school psychologists through 2010, with the shortage then continuing but declining through 2020. The majority of school districts maintained the appropriate recommended ratios for school counselors, with the exception of small and very large districts, which were over the recommended ratios.

Mental Health Services Provided by School Districts

Findings indicated that the three most frequently provided services across all districts were normative assessments, authentic assessments, and consultation. Normative assessments were the mental health service that was most likely to be provided to

students and families. Counseling and intervention services were least likely to be provided to students and families. It is not surprising that normative assessments were the most frequently provided service in the schools in Florida. These results are similar to previous literature which reported that approximately 87 percent of the nation's schools listed assessment as a frequently provided service for mental health problems (Foster, Rollefson, Doksum, Noonan, & Robinson, 2005). It was suggested that schools are more likely to provide services such as assessment rather than counseling or academic and/or behavioral support because the latter services are perceived as needing more resources and requiring a longer length of time to provide to students than assessment (Foster, Rollefson, Doksum, Noonan, & Robinson, 2005).

Perceived Qualifications of Student Services Personnel to Provide Mental Health Services

School Psychologists. Descriptive data revealed that school psychologists were perceived by student services directors and supervisors as being somewhat qualified to qualified to provide a number of different mental health services. Directors and supervisors both rated school psychologists as having the highest qualifications to provide normative assessments. Previous studies found that despite the opportunities for role expansion, school psychologists still devote a large portion of their time to assessment-related duties (Fagan & Wise, 2000). It is promising, however, that student services directors and supervisors perceive school psychologist as being qualified (needing only minimal supervision) to provide services in addition to normative assessment such as consultation, counseling, and 'Other' services (e.g., behavioral observations). Interestingly, directors of student services were more likely to rate school

psychologists as being ‘qualified’ to provide a range of mental health services than any of the supervisors of student services, including supervisors of school psychology. This result is surprising because it is often those that are within the field of school psychology that perceive school psychologists to have more skills to provide mental health services than those who are out of the field (Nastasi, Varjas, Bernstein, & Pluymert, 1998).

School Counselors. The results of this study suggest that school counselors are perceived by student services directors and supervisors as qualified to minimally qualified to provide a number of mental health services. For example, results from previous studies indicate that school counselor training typically prepares counselors to provide students with individual counseling, small group counseling, classroom guidance and consultation (Burnham & Jackson, 2000). In the present study, directors and supervisors of psychology and social work rated school counselors as somewhat qualified (needing supervision) to provide counseling and consultation. In contrast, supervisors of counseling services rated school counselors as qualified (needing minimal supervision) to provide services in counseling and consultation, as well as ‘Other’ services. These results are consistent with previous studies which suggest that professionals in the field of school counseling often have perceptions about their role which are not parallel to the perceptions held by other professionals (Burnham & Jackson, 2000). In fact, studies have found that administrators and school counselors may often disagree on the role of the school counselor. This difference in perception may be a cause of frustration for the school counselor and may serve as a barrier to the school counselor in the provision of mental health service delivery (Fitch, Newby, Ballestero, & Marshall, 2001).

School Social Workers. Directors and supervisors rated school social workers as most qualified to provide: 1) prevention, 2) 'Other', and 3) counseling services. The services which school social workers were seen as least qualified to provide were normative assessment and authentic assessment. Supervisors of school psychology rated school social workers as *not qualified* to provide authentic assessments. In a previous study, Agresta (2004) reported that school social workers spent their time engaged in counseling and consultation. School social workers indicated that they would like to spend more time engaged in individual and group counseling (Agresta, 2004). However, as the field of school social work changes to meet the demands of educational legislation and policy, school social workers will be called upon to expand their skill set to include roles such as prevention specialist, crisis manager, assessment specialist, referral agent, and case manager (Franklin, 2000). The results of this study suggest that administrators may not perceive school social workers to have the skills to meet the demands of their redefined roles without some degree of supervision.

Finally, no mental health service providers were rated as highly qualified or qualified enough to provide intervention services with minimal to no supervision. This is problematic because IDEIA (2004) allows schools to use a Response to Intervention [RtI]) model to deliver services to at-risk children and youth. In this model, school psychologists, school counselors, and school social workers may find themselves responsible for carrying out or assisting with the implementation of interventions for children in the schools. In addition, NCLB (2001) and IDEIA (2004) require that states and school districts demonstrate that the services they provide lead to academic competence and improved achievement for all students. The successful implementation

of this model is dependent on the availability of service providers who are qualified to provide interventions or to train other personnel in the implementation of interventions

Differences in Perceptions of Qualifications between Directors and Supervisors by Role and Credential

Student services directors rated school psychologists as being more qualified than school counselors and social workers to provide normative assessments. A plausible explanation for these results is that school psychologists, despite the urgency for role expansion, often spend a large portion of their professional time engaged in normative assessments for special education eligibility determination (Fagan & Wise, 2000). In addition, directors of student services perceived school psychologists and school counselors as having significantly higher qualifications to provide authentic assessment than school social workers.

Supervisors of student services rated school psychologists as more qualified than school social workers to provide consultation. School psychologists were also rated as most qualified to provide normative assessments. These results reflect outcomes of previous research which indicated that the traditional roles of school psychologists have been to provide normative assessment and consultation (Nastasi, Varjas, Bernstein, & Pluymert, 1998). Similar to the ratings of directors, supervisors rated school psychologists and school counselors as most qualified to provide authentic assessment. Lastly, school counselors were rated as more qualified than school social workers to provide intervention services, although with some supervision necessary.

When examining whether the type of credential held moderated the beliefs of directors and supervisors, relative to qualifications of school psychologists, counselors,

and school social workers to provide mental health services, results revealed that for school psychologists the main effects for service and type of credential were significant. For school counselors and social workers, only the main effect of service was significant.

An examination of the credential main effect for school psychologists indicated that professionals (directors and supervisors) with a teaching only credential rated school psychologists as being more qualified to provide mental health services than those with a student support credential. These results may suggest that professionals who are outside of the field (teaching) either believe mental health providers (school psychologists) *should* have a specific set of skills and qualifications based on professional title/role alone and thus rate them as being qualified to provide mental health services based on these beliefs. Another explanation for this result may be that professionals outside the field (teaching) recognize and/or have witnessed mental health professionals (school psychologists) delivering effective mental health services and are less likely than professionals with mental health training, to underreport the skills which they believe exist for these providers.

Impact of Mental Health Services on Academic and Behavioral Outcomes

Academic Outcomes. The top three services rated by directors and supervisors as having the most impact on academic outcomes were consultation, counseling, and authentic assessment. The majority of mental health services were rated as having a strong to fairly strong impact on academic outcomes. The once exception was by supervisors of school counseling who rated authentic assessment as having minimal impact on academic outcomes.

Behavioral Outcomes. The top three services rated by directors and supervisors as having the most impact on *behavioral* outcomes were counseling, consultation, and intervention. Counseling was reported as having the highest rating compared to other mental health services (strong impact) for strength of impact on behavioral outcomes. This is interesting, as counseling was reported as the service which was least likely to be provided to children and families. One explanation for this result could be that school districts recognize the importance of counseling, but do not have the personnel to deliver the counseling services (Foster, Rollefson, Doksum, Noonan, & Robinson, 2005).

Differences in Perceptions between Directors and Supervisors by Role and Credential. For *academic* outcomes, counseling and consultation were rated as having a significantly stronger impact than normative and authentic assessment, prevention and intervention. Counseling and consultation were rated as having a significantly stronger impact on *behavioral* outcomes than normative and authentic assessment, prevention and intervention. In addition, counseling was rated as having a significantly stronger impact than consultation. This is an interesting result, as consultation services have been found in the literature to be a highly effective service delivered to students and families and can impact a larger number of students at once than one on one direct counseling (Kratchowill, Elliott & Busse, 1995). It is plausible that the perceptions in this current study exist because administrators may be unfamiliar with how effective consultation services can be for students and families. Perhaps they are unaware of the literature which demonstrates the effectiveness of consultation and how it is an evidenced-based practice which can produce long-lasting results for both behavior and academics.

Student services *directors* with a teaching only credential rated mental health services as having a higher impact on academic outcomes than student services *supervisors* with a teaching only credential. No differences in ratings existed between supervisors and directors who held a student support credential. For *behavioral* outcomes it was observed that directors with a teaching only credential rated mental health services as having a significantly higher impact on behavioral outcomes than student services supervisors with a teaching only credential. In addition, there were no differences in ratings between directors and supervisors with a student support credential. The implication of such results are that in districts where mental health providers have *student services supervisors* with a teaching only credential, they may have to be stronger advocates about the relationship between mental health services and student outcomes. Additionally, these results may suggest that in districts where the *student services supervisors* have a teaching only credential, mental health providers may receive less support for the delivery of a wide range of mental health services, because there is not a strong and established understanding of the relationship between mental health services and student outcomes (Flaherty, Weist, & Warner, 1996).

Limitations

There were several limitations to the present study. One limitation was sampling bias. The sample that was used was only educational administrators (directors and supervisors) who were employed as student services directors and supervisors of student services in the state of Florida. Therefore, the results of this study can only be generalized to student services directors and supervisors and not to other educational administrators in Florida or outside of Florida (Cozby, 2001).

A second limitation was that participants may have been inclined to provide socially desirable responses (Cozby, 2001). By administering a survey about mental health service delivery in the schools, the researcher was assuming that educational administrators believe that mental health services are being provided at some level, within schools. If a district was providing few or no mental health services, respondents may have been inclined to over-represent or under-represent the range of mental health services offered to students in their district. They also may have been inclined to misrepresent their beliefs about the link between specific mental health services and student outcomes (e.g., academic or behavior). Allowing participants to know the purpose of the study may have contributed to them providing inaccurate or false information about their actual perceptions of the relationship between mental health services and student outcomes (Cozby, 2001).

The third limitation is related to the instrument used and represents a potential threat to internal validity. The survey had a specific question in which it asked student service directors to recall the mental health services which were provided in their districts. This approach introduces the problem of recall bias (Johnson & Christensen, 2004). Student services directors may not have accurately recalled the types of services that their districts provided. They had to reflect back on their previous experiences or knowledge and this may have resulted in inaccurate information being provided.

The fourth limitation potentially impacting this study was the somewhat low response rate of student services directors. According to Babbie (1990), a response rate of at least 50% is generally considered adequate for the analysis and reporting of survey information. This survey achieved a 38.8% response rate from student services directors,

therefore, the results from the directors should be considered preliminary and interpreted cautiously.

Implications for Training and Practice and Future Directions for Research

Presently no research has been found regarding the relationship between administrator beliefs about school-based mental health services, school mental health providers' qualifications to provide such services, and the link between mental health services and student outcomes as moderated by the professional role (directors and supervisors) and type of credential held by the administrator. The findings of this study indicate that directors and supervisors reported significantly different ratings about the level of qualifications of school psychologists, school counselors, and school social workers to provide mental health services. The implications of such results may be that mental health service providers are encouraged to deliver only those mental health services which they are *perceived by administrators* to be qualified to provide, even if, they have the skills and training to provide other services. This is supported by the results in the present study. The results reveal that the mental health services which administrators perceive school psychologists, school counselors, and/or school social workers as "most" qualified to provide (normative assessment, authentic assessment and consultation), based on their skills and training, are also the services in the district which are most frequently provided. Thus, perceptions about the types of mental health services which mental health service providers are qualified to provide is linked to the range of mental health services offered in districts (Adelman & Taylor, 1998).

It is important based on the results in the current study that if mental health providers are actually qualified to provide more mental health services than what is

perceived, that the mental health service providers advocate more to administrators about their additional skills and qualifications. Also the implications of these results for training are that mental health service providers should advocate for training program models of practice and research which include cross-disciplinary partnerships (Fantuzzo, McWayne, & Bulotsky, 2003). The development of such training models will promote collaboration amongst mental health service providers and ensure that they have shared skills and qualifications in the school mental health service delivery system.

In addition, the type of credential held by directors and supervisors moderated their beliefs about the impact of mental health services on academic and behavioral outcomes. This result is significant because it reveals that it is not only the type of administrative position which is held (director or supervisor) which influences perceptions, but it is also the preparation and the type of credential held (teaching only or student support) which matters. It is important that when districts are appointing individuals to administrative positions they examine the training and background of these professionals. For example, in this study the type of credential held moderated the beliefs of directors and supervisors about the impact of mental health services on academic and behavioral outcomes. These results suggest that the type of credential held by a student service director or supervisor may influence a district's emphasis or de-emphasis which is placed on the relationship between mental health services and academic and/or behavioral outcomes. For students and families, this influences whether their environment provides services that seek to increase academic or behavioral competence and promote positive mental health or whether it emphasizes immediate placement in restrictive settings (e.g., special education) as a result of academic, behavior, and/or

emotional failure. Therefore, districts must emphasize that the specific training and preparation of their leadership staff align with the goals and policy of the district, with respect to providing school-based mental health services.

Based on the current research, there are several recommendations which are suggested for future research. One suggestion for future research is that this instrument be used repeatedly in other states to compare the consistency of results about school mental health services across states. Research has shown that there are differences in service use and unmet need for children's mental health services across states and that many of those differences are driven by state-level factors, such as policy, legislation, and funding for children's mental health care (McDaniel & Edwards, 2004). In addition, repeated usage of the instrument could allow the researcher to make changes to the instrument, such as modifying questions, or changing the order of the questions to ensure the best possible results. Another possible suggestion for future research using the instrument, involves changing the format of administration. In the current study, the researcher used both a paper-based version of the survey which was mailed and an email attachment version of the survey. It was found that the response rate for the paper-based version was slightly lower (21%) than the response rate for the email attachment version (37%). Literature has indicated that there is an increasing popularity and wide availability of the World Wide Web in schools and web-based surveys provide educational researchers with a vehicle for lowering the cost of and easing the effort required to collect and analyze data (Lang, Raver, White, Hogarty & Kromrey, 2000). Therefore, future research may involve administering the instrument as a web-based survey.

Second, future research should further explore the ratings of student service directors and supervisors about the qualifications of mental health service providers to provide mental health services. It was found in the current study that directors and supervisors did not rate any of the mental health service providers as highly qualified or qualified to provide interventions without minimal/no supervision. Schools are being encouraged by recent legislation and policy to use evidenced-based practices and interventions to promote student success and achievement in schools. However, if service providers are perceived as not highly qualified or qualified to provide interventions or train other personnel in the implementation of interventions, then the treatment fidelity of this approach will be immensely impacted. Qualitative research should be conducted to explore who are the professionals which directors and supervisors believe are qualified to highly qualified to provide intervention services in schools. In addition, future research should further explore directors and supervisors perceptions and beliefs about the training and skills needed, for current school mental health providers, to become qualified enough to provide intervention services.

Third, future research should examine the relationship between student mental health services and student outcomes (academic and/or behaviorally). In the current study a number of mental health services were endorsed as having an impact on student's academic and behavioral outcomes. Future research should examine the actual impact of a mental health service and changes in academic or behavioral outcomes. In addition, future research should examine the difference in levels of distressing mental health symptoms of student's who receive or do not receive a mental health service to increase their academic or behavioral competence.

Finally, future research should examine Florida school psychologists, school social workers, and school counselor's ratings of mental health provider qualifications to provide mental health services and their ratings about the impact of mental health services on student academic and behavioral outcomes. These future results could then be contrasted to the results in this current study. The mental health service providers (school psychologists, school counselors, and school social workers) should be administered questions from the current instrument to investigate the consistency in ratings by administrators and mental health service providers. Results from this future investigation could provide information about the current state of school based mental health services in Florida and the specific areas or sets of skills for future training (i.e. intervention support) which are needed for school based mental health providers to adequately provide mental health services in schools.

Conclusion

The present study examined the types of mental health services provided to students in school districts throughout Florida and the extent to which those services were provided to children and families. In addition, the beliefs of student services directors and supervisors regarding qualifications of school mental health service providers to provide mental health services and their beliefs about the impact of mental health services on student academic and behavioral outcomes were explored. Directors and supervisors reported significantly different ratings about the level of qualifications of school psychologists, school counselors, and school social workers to provide mental health services. In addition, directors and supervisors, combined also had significantly different ratings about the types of mental health services which impacted academic and

behavioral outcomes. Limitations that are important to consider when interpreting the results of this study were noted. Implications of the findings are discussed and finally suggestions are offered for areas of future study related to school-based mental health services.

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Appendices

Appendix A: Perception of School Mental Health Services Survey (Version A)

Section I: Demographic Information

For each item below please check the option that best corresponds to your response:

1. Size of school district (FL DOE designation):
   1.____Small
   2.____Small/Middle
   3.____Middle
   4.____Large
   5.____Very Large

2. Your highest degree earned:
   1.____ Bachelor's Degree
   2.____ Masters Degree
   3.____ Specialist Degree
   4.____ Doctoral Degree

3. Area in which you earned your highest degree:
   1.____ Special Education
   2.____ General Education
   3.____ Counseling
   4.____ Psychology
   5.____ Social Work
   6.____ Administration

4. Area(s) in which you are credentialed:
   1.____ Special Education
   2.____ General Education
   3.____ Counseling
   4.____ Psychology
   5.____ Social Work
   6.____ Administration

5. Your years of experience in current position:
   1.____ 1-5
   2.____ 6-10
   3.____ 11-15
   4.____ More than 15

6. Your total years of experience in educational setting:
   1.____ 1-5
   2.____ 6-10
   3.____ 11-15
   4.____ More than 15

Student Services Directors, please answer the following questions based upon information from your school district ***during the 2005-2006*** *school year:*

7. Check the *one* that **best** describes your professional role:
   1.____ Student Services Director
   2.____ Student Services Director/ESE Director

8. Number of FTE* school/licensed psychologists employed/contracted in district:
   _____

9. Number of FTE* school counselors employed in district:
   _____

10. Number of FTE* school social workers employed in district:
    _____

11. Total number of students enrolled in district:
    _____

12. Total number (or percent) of students that are minority or non-white:
    Number_____ Percent_____

13. Total number (or percent) of students on free/reduced lunch:
    Number_____Percent_____

14. Total number (or percent) of students who are enrolled in EH/SED programs:
    Number_____ Percent_____

15. Total number (or percent) of students who are enrolled in alternative education programs:
    Number_____Percent_____

16. Total number (or percent) of students suspended:
    Number_____ Percent_____

17. Total number (or percent) of students expelled:
    Number_____ Percent_____

18. Total number of Baker Act referrals (including cases of students with multiple referrals):
    _____

* Full-Time Equivalent 5 days a week= 1 FTE
1 day a week= .2 FTE

Section II: Information on Mental Health Services

19. For each of the following **mental health services listed below,** please rate the level at which the service is provided to students/families in your district.

    Use the following response scale:
    5=Provided to all student(s)/families who need the service
    4=Provided to most students/families who need the service
    3=Provided to some student(s)/families when the service is available
    2=Provided to student(s)/families on a very limited basis
    1=Not provided to student(s)/families/Service is unavailable

    Please circle the rating that best represents your response.

Service	Level Provided				
Counseling					
1. Individual therapy/counseling	5	4	3	2	1
2. Family therapy/counseling	5	4	3	2	1
3. Group therapy/counseling	5	4	3	2	1
Consultation					
1. Mental health consultation	5	4	3	2	1
2. Behavior management consultation	5	4	3	2	1
3. Academic consultation/interventions	5	4	3	2	1
Norm-Referenced Assessments					
1. Intelligence Assessment	5	4	3	2	1
2. Cognitive Assessment	5	4	3	2	1
3. Personality Assessment	5	4	3	2	1

4. Behavior Rating Scale	5	4	3	2	1
Authentic Assessments					
1. Dynamic Indicators of Basics Early Literacy Skills	5	4	3	2	1
2. Curriculum Based Measurement	5	4	3	2	1
Prevention					
1. Early intervention services/School-wide screenings	5	4	3	2	1
2. Home Visitations/Community Outreach	5	4	3	2	1
3. Character Education	5	4	3	2	1
4. Parent Training	5	4	3	2	1
5. Substance Abuse Prevention/Counseling	5	4	3	2	1
6. Violence Prevention/Counseling	5	4	3	2	1
7. Suicide Prevention	5	4	3	2	1
8. Pregnancy Prevention/Support	5	4	3	2	1
9. Bullying Prevention	5	4	3	2	1
10. Dropout Prevention	5	4	3	2	1
11. Peer mediation/support groups	5	4	3	2	1
Intervention					
1. Positive Behavior Support	5	4	3	2	1
2. Social skills training	5	4	3	2	1
3. Test taking and study skills training	5	4	3	2	1
4. Crisis intervention	5	4	3	2	1
5. Anger Control Training	5	4	3	2	1
6. Relaxation Training	5	4	3	2	1
Other					
1. Clinical Interviews	5	4	3	2	1
2. Behavioral Observations	5	4	3	2	1
3. Case Management (coordination of services)	5	4	3	2	1
4. Research and Evaluation	5	4	3	2	1
5. Other (Please Specify): _____	5	4	3	2	1

20. For the following **mental health services <u>offered</u>** in your district, please rate the extent to which you believe *school psychologists, social workers, and school counselors* are *qualified* to provide each service, based on their educational and professional training.

    Use the following response scale:
    5= highly qualified no supervision needed
    4=qualified and minimal supervision needed
    3=somewhat qualified and supervision is needed
    2= minimally qualified and intense supervision needed
    1=Not qualified

    Please circle the rating that best represents your response for each service provider.

Service	School Psychologist	School Counselor	Social Worker
<u>Counseling</u>			
1. Individual therapy/counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Family therapy/counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Group therapy/counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
<u>Consultation</u>			
1. Mental health consultation	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Behavior management consultation	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Academic consultation/interventions	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
<u>Norm-Referenced Assessments</u>			
1. Intelligence Assessment	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Cognitive Assessment	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Personality Assessment	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Behavior Rating Scale	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1

Authentic Assessments			
1. Dynamic Indicators of Basics Early Literacy Skills	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Curriculum Based Measurement	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Prevention			
1. Early intervention services/School-wide screenings	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Home Visitations/Community Outreach	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Character Education	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Parent Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
5. Substance Abuse Prevention/Counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
6. Violence Prevention/Counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
7. Suicide Prevention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
8. Pregnancy Prevention/Support	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
9. Bullying Prevention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
10. Dropout Prevention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
11. Peer mediation/support groups	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Intervention			
1. Positive Behavior Support	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Social skills training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Test taking and study skills training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Crisis intervention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
5. Anger Control Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
6. Relaxation Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
7. Self Control Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Other			
1. Clinical Interviews	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Behavioral Observations	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Case Management (coordination of services)	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Research and Evaluation	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1

21. For each of the following mental health services please rate the degree of impact that you believe the service has in a) academic and b) behavioral outcomes of students?

    Using the following rating scale for each outcome (academic and behavioral), please circle the best rating that best represents your response.

    5= Very strong impact
    4= Strong impact
    3= Fairly strong impact
    2= Minimal impact
    1= No impact

    Please circle the rating that best represents your response as shown in the example below.

	Example	**Academic**	**Behavior**
	Item 1	(5) 4 3 2 1	5 4 3 2 (1)

Service	Academic	Behavior
Counseling		
1. Individual therapy/counseling	5 4 3 2 1	5 4 3 2 1
2. Family therapy/counseling	5 4 3 2 1	5 4 3 2 1
3. Group therapy/counseling	5 4 3 2 1	5 4 3 2 1
Consultation		
1. Mental health consultation	5 4 3 2 1	5 4 3 2 1
2. Behavior management consultation	5 4 3 2 1	5 4 3 2 1
3. Academic consultation/interventions	5 4 3 2 1	5 4 3 2 1

Norm-Referenced Assessments		
1. Intelligence Assessment	5 4 3 2 1	5 4 3 2 1
2. Cognitive Assessment	5 4 3 2 1	5 4 3 2 1
3. Personality Assessment	5 4 3 2 1	5 4 3 2 1
4. Behavior Rating Scale	5 4 3 2 1	5 4 3 2 1
Authentic Assessment		
1. Dynamic Indicators of Basics Early Literacy Skills	5 4 3 2 1	5 4 3 2 1
2. Curriculum Based Measurement	5 4 3 2 1	5 4 3 2 1
Prevention		
1. Early intervention services	5 4 3 2 1	5 4 3 2 1
2. Home Visitations/Community Outreach	5 4 3 2 1	5 4 3 2 1
3. Character Education	5 4 3 2 1	5 4 3 2 1
4. Parent Training	5 4 3 2 1	5 4 3 2 1
5. Substance Abuse Prevention/Counseling	5 4 3 2 1	5 4 3 2 1
6. Violence Prevention/Counseling	5 4 3 2 1	5 4 3 2 1
7. Suicide Prevention	5 4 3 2 1	5 4 3 2 1
8. Pregnancy Prevention/Support	5 4 3 2 1	5 4 3 2 1
9. Bullying Prevention	5 4 3 2 1	5 4 3 2 1
10. Dropout Prevention	5 4 3 2 1	5 4 3 2 1
11. Peer mediation/support groups	5 4 3 2 1	5 4 3 2 1
Intervention		
1. Positive Behavior Support	5 4 3 2 1	5 4 3 2 1
2. Social skills training	5 4 3 2 1	5 4 3 2 1
3. Test taking and study skills training	5 4 3 2 1	5 4 3 2 1
4. Crisis intervention	5 4 3 2 1	5 4 3 2 1
5. Anger Control Training	5 4 3 2 1	5 4 3 2 1
6. Relaxation Training	5 4 3 2 1	5 4 3 2 1
7. Self Control Training	5 4 3 2 1	5 4 3 2 1

Other		
1. Clinical Interviews	5 4 3 2 1	5 4 3 2 1
2. Behavioral Observations	5 4 3 2 1	5 4 3 2 1
3. Case Management (coordination of services)	5 4 3 2 1	5 4 3 2 1
4. Research and Evaluation	5 4 3 2 1	5 4 3 2 1

22. For each support service listed below, please indicate the extent to which it is **actually** utilized to monitor the progress of students who have returned to school after receiving an involuntary examination according to Baker Act statutes.

Use the following response scale:
5= Always used
4= Frequently used
3= Sometimes used
2= Seldom used
1= Not Used

Please circle the rating that best represents your response.

Service	Level Provided
Intervention	
1. Referred to school based intervention team	5 4 3 2 1
2. Referred to community based mental health service provider for counseling	5 4 3 2 1
3. Referred to school based psychologist for counseling	5 4 3 2 1
4. Referred to guidance counselor for counseling	5 4 3 2 1
5. Referred to social worker for counseling	5 4 3 2 1
6. Referred to school nurse	5 4 3 2 1
7. Referred to Safe and Drug Free School Staff	5 4 3 2 1
8. Home-school intervention/collaboration.	5 4 3 2 1

Assessment

1. Referred to student services personnel for special education evaluation. 5 4 3 2 1

2. Referred to student services personnel for a Functional Behavior Assessment. 5 4 3 2 1

Consultation

1. Student service personnel assigned as case manager. 5 4 3 2 1

2. Consultation provided by community mental health provider. 5 4 3 2 1

3. Consultation provided to classroom teachers. 5 4 3 2 1

Appendix B: Perception of School Mental Health Services Survey (Version B)

Section I: Demographic Information

For each item below please check the option that best corresponds to your response:

1. Size of school district (FL DOE designation):
   1.____Small
   2.____Small/Middle
   3.____Middle
   4.____Large
   5.____Very Large

2. Your highest degree earned:
   1.____ Bachelor's Degree
   2.____ Masters Degree
   3.____ Specialist Degree
   4.____ Doctoral Degree

3. Area in which you earned your highest degree:
   1.____ Special Education
   2.____ General Education
   3.____ Counseling
   4.____ Psychology/School Psychology
   5.____ Social Work
   6.____ Administration

4. Area(s) in which you are credentialed:
   1.____ Special Education
   2.____ General Education
   3.____ Counseling
   4.____ Psychology/School Psychology
   5.____ Social Work

5. Your years of experience in current position:
   1.____ 1-5
   2.____ 6-10
   3.____ 11-15
   4.____ More than 15

6. Your total years of experience in educational setting:
   1.____ 1-5
   2.____ 6-10
   3.____ 11-15
   4.____ More than 15

7. Check the *one* that best describes your professional role:
   1.____ Director/Supervisor of Psychological Services
   2.____ Director/Supervisor of Guidance and Counseling Services

Section II: Information on Mental Health Services

8. For each of the following **mental health services listed below,** please rate the level at which the service is provided to students/families in your district.

   Use the following response scale:
   5=Provided to all student(s)/families who need the service
   4=Provided to most students/families who need the service
   3=Provided to some student(s)/families when the service is available
   2=Provided to student(s)/families on a very limited basis
   1=Not provided to student(s)/families/Service is unavailable

   Please circle the rating that best represents your response.

Service	Level Provided				
Counseling					
1. Individual therapy/counseling	5	4	3	2	1
2. Family therapy/counseling	5	4	3	2	1
3. Group therapy/counseling	5	4	3	2	1
Consultation					
1. Mental health consultation	5	4	3	2	1
2. Behavior management consultation	5	4	3	2	1
3. Academic consultation/interventions	5	4	3	2	1
Norm-Referenced Assessments					
1. Intelligence Assessment	5	4	3	2	1
2. Cognitive Assessment	5	4	3	2	1
3. Personality Assessment	5	4	3	2	1
4. Behavior Rating Scale	5	4	3	2	1

Authentic Assessments					
1. Dynamic Indicators of Basics Early Literacy Skills	5	4	3	2	1
2. Curriculum Based Measurement	5	4	3	2	1
Prevention					
1. Early intervention services/School-wide screenings	5	4	3	2	1
2. Home Visitations/Community Outreach	5	4	3	2	1
3. Character Education	5	4	3	2	1
4. Parent Training	5	4	3	2	1
5. Substance Abuse Prevention/Counseling	5	4	3	2	1
6. Violence Prevention/Counseling	5	4	3	2	1
7. Suicide Prevention	5	4	3	2	1
8. Pregnancy Prevention/Support	5	4	3	2	1
9. Bullying Prevention	5	4	3	2	1
10. Dropout Prevention	5	4	3	2	1
11. Peer mediation/support groups	5	4	3	2	1
Intervention					
1. Positive Behavior Support	5	4	3	2	1
2. Social skills training	5	4	3	2	1
3. Test taking and study skills training	5	4	3	2	1
4. Crisis intervention	5	4	3	2	1
5. Anger Control Training	5	4	3	2	1
6. Relaxation Training	5	4	3	2	1
7. Self-Control Training	5	4	3	2	1
Other					
1. Clinical Interviews	5	4	3	2	1
2. Behavioral Observations	5	4	3	2	1
3. Case Management (coordination of services)	5	4	3	2	1
4. Research and Evaluation	5	4	3	2	1
5. Other (Please Specify): _____	5	4	3	2	1

9. For the following **mental health services <u>offered</u>** in your district, please rate the extent to which you believe *school psychologists, social workers, school counselor* are *qualified* to provide each service, based on their educational and professional training.

   Use the following response scale:
   5= highly qualified no supervision needed
   4=qualified and minimal supervision needed
   3=somewhat qualified and supervision is needed
   2= minimally qualified and intense supervision needed
   1=Not qualified

   Please circle the rating that best represents your response for each service provider.

Service	School Psychologist	School Counselor	Social Worker
<u>Counseling</u>			
1. Individual therapy/counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Family therapy/counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Group therapy/counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
<u>Consultation</u>			
1. Mental health consultation	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Behavior management consultation	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Academic consultation/interventions	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
<u>Norm-Referenced Assessments</u>			
1. Intelligence Assessment	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Cognitive Assessment	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Personality Assessment	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Behavior Rating Scale	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1

Authentic Assessments			
1. Dynamic Indicators of Basics Early Literacy Skills	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Curriculum Based Measurement	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Prevention			
1. Early intervention services/School-wide screenings	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Home Visitations/Community Outreach	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Character Education	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Parent Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
5. Substance Abuse Prevention/Counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
6. Violence Prevention/Counseling	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
7. Suicide Prevention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
8. Pregnancy Prevention/Support	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
9. Bullying Prevention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
10. Dropout Prevention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
11. Peer mediation/support groups	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Intervention			
1. Positive Behavior Support	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Social skills training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Test taking and study skills training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Crisis intervention	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
5. Anger Control Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
6. Relaxation Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
7. Self Control Training	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
Other			
1. Clinical Interviews	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
2. Behavioral Observations	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
3. Case Management (coordination of services)	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1
4. Research and Evaluation	5 4 3 2 1	5 4 3 2 1	5 4 3 2 1

10. For each of the following mental health services please rate the degree of impact that you believe the service has in a) academic and b) behavioral outcomes of students?

    Using the following rating scale for each outcome (academic and behavioral), please circle the best rating that best represents your response.

    5= Very strong impact
    4= Strong impact
    3= Fairly strong impact
    2= Minimal impact
    1= No impact

    Please circle the rating that best represents your response as shown in the example below.

	Example	**Academic**	**Behavior**
	Item 1	(5) 4 3 2 1	5 4 3 2 (1)

Service	Academic	Behavior
Counseling		
1. Individual therapy/counseling	5 4 3 2 1	5 4 3 2 1
2. Family therapy/counseling	5 4 3 2 1	5 4 3 2 1
3. Group therapy/counseling	5 4 3 2 1	5 4 3 2 1
Consultation		
1. Mental health consultation	5 4 3 2 1	5 4 3 2 1
2. Behavior management consultation	5 4 3 2 1	5 4 3 2 1
3. Academic consultation/interventions	5 4 3 2 1	5 4 3 2 1

Norm-Referenced Assessments		
1. Intelligence Assessment	5 4 3 2 1	5 4 3 2 1
2. Cognitive Assessment	5 4 3 2 1	5 4 3 2 1
3. Personality Assessment	5 4 3 2 1	5 4 3 2 1
4. Behavior Rating Scale	5 4 3 2 1	5 4 3 2 1
Authentic Assessment		
1. Dynamic Indicators of Basics Early Literacy Skills	5 4 3 2 1	5 4 3 2 1
2. Curriculum Based Measurement	5 4 3 2 1	5 4 3 2 1
Prevention		
1. Early intervention services	5 4 3 2 1	5 4 3 2 1
2. Home Visitations/Community Outreach	5 4 3 2 1	5 4 3 2 1
3. Character Education	5 4 3 2 1	5 4 3 2 1
4. Parent Training	5 4 3 2 1	5 4 3 2 1
5. Substance Abuse Prevention/Counseling	5 4 3 2 1	5 4 3 2 1
6. Violence Prevention/Counseling	5 4 3 2 1	5 4 3 2 1
7. Suicide Prevention	5 4 3 2 1	5 4 3 2 1
8. Pregnancy Prevention/Support	5 4 3 2 1	5 4 3 2 1
9. Bullying Prevention	5 4 3 2 1	5 4 3 2 1
10. Dropout Prevention	5 4 3 2 1	5 4 3 2 1
11. Peer mediation/support groups	5 4 3 2 1	5 4 3 2 1
Intervention		
1. Positive Behavior Support	5 4 3 2 1	5 4 3 2 1
2. Social skills training	5 4 3 2 1	5 4 3 2 1
3. Test taking and study skills training	5 4 3 2 1	5 4 3 2 1
4. Crisis intervention	5 4 3 2 1	5 4 3 2 1
5. Anger Control Training	5 4 3 2 1	5 4 3 2 1
6. Relaxation Training	5 4 3 2 1	5 4 3 2 1
7. Self Control Training	5 4 3 2 1	5 4 3 2 1

Other		
1. Clinical Interviews	5 4 3 2 1	5 4 3 2 1
2. Behavioral Observations	5 4 3 2 1	5 4 3 2 1
3. Case Management (coordination of services)	5 4 3 2 1	5 4 3 2 1
4. Research and Evaluation	5 4 3 2 1	5 4 3 2 1

11. For each support service listed below, please indicate the extent to which it is **actually** utilized to monitor the progress of students who have returned to school after receiving an involuntary examination according to Baker Act statutes.

    Use the following response scale:
    5= Always used
    4= Frequently used
    3= Sometimes used
    2= Seldom used
    1= Not Used

    Please circle the rating that best represents your response.

Service	Level Provided
Intervention	
1. Referred to school based intervention team	5 4 3 2 1
2. Referred to community based mental health service provider for counseling	5 4 3 2 1
3. Referred to school based psychologist for counseling	5 4 3 2 1
4. Referred to guidance counselor for counseling	5 4 3 2 1
5. Referred to social worker for counseling	5 4 3 2 1

6. Referred to school nurse	5 4 3 2 1
7. Referred to Safe and Drug Free School Staff	5 4 3 2 1
8. Home-school intervention/collaboration.	5 4 3 2 1
Assessment	
1. Referred to student services personnel for special education evaluation.	5 4 3 2 1
2. Referred to student services personnel for a Functional Behavior Assessment.	5 4 3 2 1
Consultation	
1. Student service personnel assigned as case manager.	5 4 3 2 1
2. Consultation provided by community mental health provider.	5 4 3 2 1
3. Consultation provided to classroom teachers.	5 4 3 2 1

Appendix C: Informed Consent for Directors of Student Services (Version A)

You are receiving this letter because you were selected from the Florida Student Support Services Directory from the Florida Department of Education. As providers of students support services, we are sure you are well aware that conditions contributing to student mental health problems—substance abuse, poverty, homelessness, community violence, and physical abuse—are rapidly becoming a part of the "normal" family culture within which many students grow and develop. These conditions do not foster an environment in which children can meet expected developmental, cognitive, social and emotional demands. However, schools are expected to educate all students, including the growing population of students whose mental health problems often impede or interfere with their learning. According to the Elementary and Secondary Education Act of 2001, No Child Left Behind, schools are also expected to create environments in which all students can succeed and providing mental health services in the school is a way that schools can create this type of successful environment.

Decia N. Dixon, a school psychology doctoral student at the University of South Florida is conducting a thesis study entitled "Perceptions of School Based Mental Health Services by Directors and Supervisors of Student Services" to determine the beliefs of directors/supervisors of student services as they relate to school based mental health services and delivery. The information in this letter is provided to help you decide whether or not you want to take part in this research study. Please read this information carefully. If you have any questions or concerns, please contact the principal investigator (Decia N. Dixon, School Psychology Doctoral Student).

General Information about the Research Study

You are being asked to complete a brief (15-20 minute) survey developed to acquire information about your beliefs of school based mental health services. Mental health issues embody those characteristics and factors, which closely relate to mental well-being. The lack of mental well-being is characterized by an inability to adapt to one's environment and regulate behavior (Webster's, 2002).

Your input is very important and it will be used to develop a state database regarding the range in types of mental health services provided to students in school districts throughout Florida. It will also be used to examine the impact of mental health services on student behavior and academic outcomes. The results from this study can be used in pre-service training for mental health professionals, by providing information about how directors and supervisors of student services view mental health services in the schools. Secondly, your input can contribute to school based mental health policy literature.

Plan of Study

The enclosed survey contains 22 items, 18 items which are district demographic information and 4 items that collect data about the types of mental health services provided and the perceptions about those who provide these mental health services and the impact of specified mental health services on academic and behavioral outcomes. The total time needed to complete this survey is estimated be less than 30 minutes. Please make sure that all items are completed before submitting the survey. **For your convenience, we have provided you with a postage-paid envelope to use in returning the survey to us by Jan 5th, 2007.**

Compensation

Three participants who return the completed survey will be randomly selected to receive a **$25.00** ***American Express Gift Card*** which can be used virtually everywhere in the United States that welcomes American Express Cards. Ten additional participants who return completed surveys will also be randomly selected to receive the newly published book by the National Association of State Directors of Special Education, ***Response to Intervention:Policy Considerations and Implementation***. Even though each participant will not receive direct personal benefits from this study, by participating in this study you may increase our overall knowledge of issues surrounding the provision of school mental health services and its impact on student outcomes.

Risks or Discomfort

There are no known risks to those who take part in this study.

Confidentiality of Your Records

Your privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, employees of the Department of Health and Human Services, and the USF Institutional Review Board, staff and other individuals acting on behalf of USF may inspect the records from this research project. The results of this study may be published. However, the data obtained from you will be combined with data from others. The published results will not include your name or any other information that would personally identify you in any way.

Volunteering to Be Part of this Research Study

Your decision to participate in this research study is completely voluntary. You are free to participate in this research study or to withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive, if you stop taking part in the study. If you have questions about your rights as a person who is taking part in a study, call USF Division of Research Compliance and Integrity at (813) 974-9343. If you have any questions about this research study, contact Decia N. Dixon, M.A. at 678-524-5325 or at dndixon@mail.usf.edu or George Batsche, Ed.D., NCSP at 813-974-9472 or batsche@tempest.coedu.usf.edu. Thank you very much for your participation.

Sincerely,
Decia N. Dixon, M.A. & George M. Batsche, Ed.D.

Consent to Take Part in this Research Study

If you have agreed to take part in this study then please read the following statement and sign below:

I freely give my consent to take part in this study. I understand that this is research. I have received a copy of this consent form.

_____	_____	_____
Signature of Person taking part in study	Printed Name of Person taking part in study	Date
_____	_____	_____
[Optional] Signature of Witness	Printed Name of Witness	Date

Appendix D: Informed Consent for Supervisors of Student Services (Version B)

You are receiving this letter because you were selected from the Florida Student Support Services Directory from the Florida Department of Education. As providers of students support services, we are sure you are well aware that conditions contributing to student mental health problems—substance abuse, poverty, homelessness, community violence, and physical abuse—are rapidly becoming a part of the "normal" family culture within which many students grow and develop. These conditions do not foster an environment in which children can meet expected developmental, cognitive, social and emotional demands. However, schools are expected to educate all students, including the growing population of students whose mental health problems often impede or interfere with their learning. According to the Elementary and Secondary Education Act of 2001, No Child Left Behind, schools are also expected to create environments in which all students can succeed and providing mental health services in the school is a way that schools can create this type of successful environment.

Decia N. Dixon, a school psychology doctoral student at the University of South Florida is conducting a thesis study entitled "Perceptions of School Based Mental Health Services by Directors and Supervisors of Student Services" to determine the beliefs of directors/supervisors of student services as they relate to school based mental health services and delivery. The information in this letter is provided to help you decide whether or not you want to take part in this research study. Please read this information carefully. If you have any questions or concerns, please contact the principal investigator (Decia N. Dixon, School Psychology Doctoral Student).

General Information about the Research Study

You are being asked to complete a brief (15-20 minute) survey developed to acquire information about your beliefs of school based mental health services. Mental health issues embody those characteristics and factors, which closely relate to mental well-being. The lack of mental well-being is characterized by an inability to adapt to one's environment and regulate behavior (Webster's, 2002). Mental health services are those services provided directly by a mental health professional (i.e. school psychologist, school counselor, school social worker), at the district, building, classroom, or individual student level. These services are targeted at optimizing developmental skills or behaviors that increase the probability of school success.

Your input is very important and it will be used to develop a state database regarding the range in types of mental health services provided to students in school districts throughout Florida. It will also be used to examine the impact of mental health services on student behavior and academic outcomes. The results from this study can be used in pre-service training for mental health

professionals, by providing information about how directors and supervisors of student services view mental health services in the schools. Secondly, your input can contribute to school based mental health policy literature.

Plan of Study

The enclosed survey contains 11 items, 7 items which are district demographic information and 4 items that collect data about the types of mental health services provided and the perceptions about those who provide these mental health services and the impact of specified mental health services on academic and behavioral outcomes.
The total time needed to complete this survey is estimated be less than 30 minutes. Please make sure that all items are completed before submitting the survey. **For your convenience, we have provided you with a postage-paid envelope to use in returning the survey to us by Jan 5th, 2007.**

Compensation

Three participants who return the completed survey will be randomly selected to receive a **$25.00** ***American Express Gift Card*** which can be used virtually everywhere in the United States that welcomes American Express Cards. Ten additional participants who return completed surveys will also be randomly selected to receive the newly published book by the National Association of State Directors of Special Education, ***Response to Intervention:Policy Considerations and Implementation***. Even though each participant will not receive direct personal benefits from this study, by participating in this study you may increase our overall knowledge of issues surrounding the provision of school mental health services and its impact on student outcomes.

Risks or Discomfort

There are no known risks to those who take part in this study.

Confidentiality of Your Records

Your privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, employees of the Department of Health and Human Services, and the USF Institutional Review Board, staff and other individuals acting on behalf of USF may inspect the records from this research project. The results of this study may be published. However, the data obtained from you will be combined with data from others. The published results will not include your name or any other information that would personally identify you in any way.

Volunteering to Be Part of this Research Study

Your decision to participate in this research study is completely voluntary. You are free to participate in this research study or to withdraw at any time. There will be no penalty or loss of benefits you are entitled to receive, if you stop taking part in the study. If you have questions about your rights as a person who is taking part in a study, call USF Division of Research Compliance and Integrity at (813) 974-9343. If you have any questions about this research study, contact Decia N. Dixon, M.A. at 678-524-5325 or at dndixon@mail.usf.edu or George Batsche, Ed.D., NCSP at 813-974-9472 or batsche@tempest.coedu.usf.edu.). Thank you very much for your participation.

Sincerely,
Decia N. Dixon, M.A. & George M. Batsche, Ed.D.

Consent to Take Part in this Research Study

If you have agreed to take part in this study then please read the following statement and sign below:

I freely give my consent to take part in this study. I understand that this is research. I have received a copy of this consent form.

_____	_____	_____
Signature of Person taking part in study	Printed Name of Person taking part in study	Date
_____	_____	_____
[Optional] Signature of Witness	Printed Name of Witness	Date

Appendix E: Pilot Study Cover Letter and Review Form for Student Services Directors (Version A)

You are receiving this letter because you were selected from the Florida Student Support Services Directory from the Florida Department of Education. The purpose of this letter is to ask for your participation in the pilot version of the "Perceptions of School Based Mental Health Services by Directors and Supervisors of Student Services" study. Decia N. Dixon, a school psychology doctoral student at the University of South Florida and primary investigator of this study is conducting a thesis study. It is entitled "Perceptions of School Based Mental Health Services by Directors and Supervisors of Student Services". The purpose of this study is to find out the beliefs of directors/supervisors of student services as they relate to school based mental health services and delivery and student academic and behavioral outcomes.

Your role in this study is to evaluate the current survey for understanding of content and clarity of response choices, wording of questions, and the total time needed to complete the survey. Your feedback from the pilot study will be used to make changes to the survey, if needed. Your input will also assist the researcher in maximizing the response rate and error rate when beginning the larger final study throughout the state of Florida.

To make this pilot study successful and effective, we ask that you complete the following steps when evaluating the survey:

1) Complete the survey in its entirety, while paying close attention to the survey's directions, wording, response choices and content.
2) Using the attached pilot rating form entitled *PSMHS Version A*, please follow the directions on the form and rate the items that you completed on the survey. Feel free to add suggestions/comments under the appropriate section.
3) Mail both the survey and the attached pilot rating form in the pre-addressed, postage paid envelope to the following address by **Nov. 15th, 2006**.

Your input is important and we appreciate your willingness to take part in this pilot study. If you have questions about your rights as a person who is taking part in a pilot study, call USF Division of Research Compliance and Integrity at (813) 974-9343. If you have any questions about this research study, contact Decia N. Dixon, M.A. at 678-524-5325 or at dndixon@mail.usf.edu or George Batsche, Ed.D., NCSP at 813-974-9472 or batsche@tempest.coedu.usf.edu.

Appendix E (Continued)

PSMHS Version A

Section I. Questions 1-17. Please review each of the questions. Please determine if the question is clear or is unclear. If unclear, please make a suggestion or comment.

Question	**Clear**	**Unclear**	**Suggestion/Comment**
1. Size of school district: 1.____Small 2.____Small/Middle 3.____Middle 4.____Large 5.____Very Large	___	___	_____
2. Your highest degree earned: 1.____ Bachelor's Degree 2.____ Masters Degree 3.____ Specialist Degree 4.____ Doctoral Degree	___	___	_____
3. Area in which you earned your highest degree: 1.____ Special Education 2.____ General Education 3.____ Counseling 4.____ Psychology 5.____ Social Work 6.____ Administration	___	___	_____

	Clear	**Unclear**	**Suggestion/Comment**
4. Area(s) in which you are credentialed: 1.____ Special Education 2.____ General Education 3.____ Counseling 4.____ Psychology 5.____ Social Work 6.____ Administration	___	___	_____
5. Your years of experience in current position: 1.____ 1-5 2.____ 6-10 3.____ 11-15 4.____ More than 15	___	___	_____
6. Your total years of experience in educational setting: 1.____ 1-5 2.____ 6-10 3.____ 11-15 4.____ More than 15	___	___	_____
7. Number of FTE* school/licensed psychologists employed/contracted in district: _____	___	___	_____

	Clear	**Unclear**	**Suggestion/Comment**
8. Number of FTE* school counselors employed in district: _____	___	___	_____
9. Number of FTE* school social workers employed in district: _____	___	___	_____
10. Total number of students enrolled in district: _____	___	___	_____
11. Total number (or percent) of students that are minority or non-white: Number_____ Percent_____	___	___	_____
12. Total number (or percent) of students on free/reduced lunch: Number_____Percent_____	___	___	_____
13. Total number (or percent) of students who are enrolled in EH/SED programs: Number_____ Percent_____	___	___	_____

	Clear	Unclear	Suggestion/Comment
14. Total number (or percent) of students who are enrolled in alternative education programs: Number_____Percent_____	___	___	_____
15. Total number (or percent) of students suspended: Number_____ Percent_____	___	___	_____
16. Total number (or percent) of students expelled: Number_____ Percent_____	___	___	_____
17. Total number of Baker Act Referrals (including cases of students with multiple referrals): _____	___	___	_____

Section II.

1. Are the instructions for completing the survey clearly written and understandable?

Acceptable Needs modification Unacceptable

Suggestions/Comments:

_____
_____
_____
_____

2. In Section II, Mental Health Services are organized in seven areas. Please review each area and the services provided under each area. Make a recommendation to *include* the specific service or *exclude* the specific service. If you believe that additional services should be included under the area, please suggest the service.

Counseling	**Include**	**Exclude**	**Additional Service(s)**
1. Individual therapy/counseling	_____	_____	_____
2. Family therapy/counseling	_____	_____	_____
3. Group therapy/counseling	_____	_____	_____
Consultation			
1. Mental health consultation	_____	_____	_____
2. Behavior management consultation	_____	_____	_____
3. Academic consultation/interventions	_____	_____	_____
Norm-Referenced Assessments			
1. Intelligence Assessment	_____	_____	_____
2. Cognitive Assessment	_____	_____	_____
3. Personality Assessment	_____	_____	_____
4. Behavior Rating Scale	_____	_____	_____

	Include	Exclude	Additional Service(s)
Authentic Assessments			
1. Dynamic Indicators of Basics Early Literacy Skills	_____	_____	_____
2. Curriculum Based Measurement	_____	_____	_____
Prevention			
1. Early intervention services/School-wide screenings	_____	_____	_____
2. Home Visitations/Community Outreach	_____	_____	_____
3. Character Education	_____	_____	_____
4. Parent Training	_____	_____	_____
5. Substance Abuse Prevention/Counseling	_____	_____	_____
6. Violence Prevention/Counseling	_____	_____	_____
7. Suicide Prevention	_____	_____	_____
8. Pregnancy Prevention/Support	_____	_____	_____
9. Bullying Prevention	_____	_____	_____
10. Dropout Prevention	_____	_____	_____
11. Peer mediation/support groups	_____	_____	_____
Intervention			
1. Time management training	_____	_____	_____
2. Social skills training	_____	_____	_____
3. Test taking and study skills training	_____	_____	_____
4. Crisis intervention	_____	_____	_____
5. Anger Control Training	_____	_____	_____
6. Relaxation Training	_____	_____	_____
8. Moral Reasoning Training	_____	_____	_____
Other			
1. Clinical Interviews	_____	_____	_____
2. Behavioral Observations	_____	_____	_____
3. Case Management (coordination of services)	_____	_____	_____
4. Research and Evaluation	_____	_____	_____
5. Other (Please Specify):	_____	_____	_____

3. In Section II Support Services are organized in three areas. Please review each area and the services provided under each area. Make a recommendation to *include* the specific service or *exclude* the specific service. If you believe that additional services should be included under the area, please suggest the service.

	Include	Exclude	Additional Service(s)
Intervention			
1. Referred to school based intervention team	_____	_____	_____
2. Referred to community based mental health service provider for counseling	_____	_____	_____

Appendix E (Continued)

	Include	Exclude	Additional Service(s)
3. Referred to school based psychologist for counseling	_____	_____	_____
4. Referred to guidance counselor or social worker for counseling	_____	_____	_____
5. Home-school intervention/collaboration	_____	_____	_____
Assessment			
1. Referred to student services personnel for special education evaluation	_____	_____	_____
2. Referred to student services personnel for a Functional Behavior Assessment	_____	_____	_____
Consultation			
1. Student service personnel assigned as case manager	_____	_____	_____
2. Consultation provided by community mental health provider	_____	_____	_____
3. Consultation provided to classroom teachers	_____	_____	_____

Area

4. How long did it take to complete the entire survey?

_____

5. Are there any recommendations for additional areas or sections in the survey that are currently not present?

_____
_____
_____
_____

Appendix F: Pilot Study Cover Letter and Review Form for Student Services Supervisors (Version B)

You are receiving this letter because you were selected from the Florida Student Support Services Directory from the Florida Department of Education. The purpose of this letter is to ask for your participation in the pilot version of the "Perceptions of School Based Mental Health Services by Directors and Supervisors of Student Services" study. Decia N. Dixon, a school psychology doctoral student at the University of South Florida and primary investigator of this study is conducting a thesis study entitled "Perceptions of School Based Mental Health Services by Directors and Supervisors of Student Services" to determine the beliefs of directors/supervisors of student services as they relate to school based mental health services and delivery and student academic and behavioral outcomes.

The purpose of the pilot study is assess the current scale for understanding of content and response choices, wording of questions, and the total time needed to complete the survey. Feedback from the pilot study will be used to make changes to the scale, if needed. Input will also assist the researcher in maximizing the response rate and error rate when beginning the larger final study throughout the state of Florida.

You are being asked to complete a brief survey developed to acquire information about your beliefs of school based mental health services. Mental health issues embody those characteristics and factors, which closely relate to mental well-being. The lack of mental well-being is characterized by an inability to adapt to one's environment and regulate behavior (Webster's, 2002). Mental health services are those services provided directly by a mental health professional (i.e. school psychologist, school counselor, school social worker), at the district, building, classroom, or individual student level. These services are targeted at optimizing developmental skills or behaviors that increase the probability of school success.

The enclosed survey contains 11 items, 7 items which are district demographic information and 4 items that collect data about the types of mental health services provided and the perceptions about those who provide these mental health services and the impact of specified mental health services on academic and behavioral outcomes.
Please make sure that all items are completed before submitting the survey. For your convenience, we have provided you with a postage-paid envelope to use in returning the survey to us.

Your participation in this pilot study is crucial to the overall success of this study. By participating in the pilot study, you will assist the investigator(s) in assessing the scale for understanding and the total time needed to complete the survey. Your feedback on the survey will also help to maximize the response rate for this study and minimize participant's error rates on answers.

In order to make this pilot study successful and effective, we ask that you complete the following steps when completing and conducting the review of the survey:

4) Complete the survey in its entirety, while paying close attention to the survey's directions, wording, response choices and content.

5) Using the attached form entitled *PSMHS Version B*, please follow the directions on the form and rate the items that you completed on the survey. Feel free to add suggestions/comments under the appropriate section.
6) Mail both the survey and the attached pilot rating form in the pre-addressed, postage paid envelope to the following address by **Nov. 15th, 2006**.

Mailing Address
Decia Dixon, MA
University of South Florida
College of Education, Psychological and Social Foundations
School Psychology Program, EDU 162, Suite 180
Tampa, FL 33162

Your privacy and research records will be kept confidential to the extent of the law. Authorized research personnel, employees of the Department of Health and Human Services, and the USF Institutional Review Board, staff and other individuals acting on behalf of USF may inspect the records from this research project. The results of the study may be published. However, the data obtained from you will be combined with data from others. The published results will not include your name or any other information that would personally identify you in any way.

Your input is very important and we thank you in advance for your willingness to participate in this pilot study. If you have questions about your rights as a person who is taking part in a pilot study, call USF Division of Research Compliance and Integrity at (813) 974-9343. If you have any questions about this research study, contact Decia N. Dixon, M.A. at 678-524-5325 or at dndixon@mail.usf.edu.

Appendix F (Continued)

PSMHS Version B

Section I. Questions 1-7. Please review each of the questions. Please determine if the question is clear or is unclear. If unclear, please make a suggestion or comment.

Question	**Clear**	**Unclear**	**Suggestion/Comment**
1. Size of school district: 1.____Small 2.____Small/Middle 3.____Middle 4.____Large 5.____Very Large	___	___	_____
2. Your highest degree earned: 1.____ Bachelor's Degree 2.____ Masters Degree 3.____ Specialist Degree 4.____ Doctoral Degree	___	___	_____
3. Area in which you earned your highest degree: 1.____ Special Education 2.____ General Education 3.____ Counseling 4.____ Psychology 5.____ Social Work 6.____ Administration	___	___	_____

	Clear	**Unclear**	**Suggestion/Comment**
4. Area(s) in which you are credentialed: 1.____ Special Education 2.____ General Education 3.____ Counseling 4.____ Psychology 5.____ Social Work 6.____ Administration	___	___	_____
5. Your years of experience in current position: 1.____ 1-5 2.____ 6-10 3.____ 11-15 4.____ More than 15	___	___	_____
6. Your total years of experience in educational setting: 1.____ 1-5 2.____ 6-10 3.____ 11-15 4.____ More than 15	___	___	_____

7. Check the *one* that best describes ___ ___ _____
your professional role:

1.____ Director/Supervisor of Psychological Services
2.____ Director/Supervisor of Guidance and Counseling Services
3.____ Director/Supervisor of Social Work Services

Section II.

1. Are the instructions for completing the survey clearly written and understandable?

Acceptable Needs modification Unacceptable

Suggestions/Comments:

_____
_____
_____
_____

2. In Section II, Mental Health Services are organized in seven areas. Please review each area and the services provided under each area. Make a recommendation to *include* the specific service or *exclude* the specific service. If you believe that additional services should be included under the area, please suggest the service.

Counseling	**Include**	**Exclude**	**Additional Service(s)**
1. Individual therapy/counseling	_____	_____	_____
2. Family therapy/counseling	_____	_____	_____
3. Group therapy/counseling	_____	_____	_____
Consultation			
1. Mental health consultation	_____	_____	_____
2. Behavior management consultation	_____	_____	_____
3. Academic consultation/interventions	_____	_____	_____

	Include	Exclude	Additional Service(s)
Norm-Referenced Assessments			
1. Intelligence Assessment	_____	_____	_____
2. Cognitive Assessment	_____	_____	_____
3. Personality Assessment	_____	_____	_____
4. Behavior Rating Scale	_____	_____	_____
Authentic Assessments			
1. Dynamic Indicators of Basics Early Literacy Skills	_____	_____	_____
2. Curriculum Based Measurement	_____	_____	_____
Prevention			
1. Early intervention services/School-wide screenings	_____	_____	_____
2. Home Visitations/Community Outreach	_____	_____	_____
3. Character Education	_____	_____	_____
4. Parent Training	_____	_____	_____
5. Substance Abuse Prevention/Counseling	_____	_____	_____
6. Violence Prevention/Counseling	_____	_____	_____
7. Suicide Prevention	_____	_____	_____
8. Pregnancy Prevention/Support	_____	_____	_____
9. Bullying Prevention	_____	_____	_____
10. Dropout Prevention	_____	_____	_____
11. Peer mediation/support groups	_____	_____	_____
Intervention			
1. Time management training	_____	_____	_____
2. Social skills training	_____	_____	_____
3. Test taking and study skills training	_____	_____	_____
4. Crisis intervention	_____	_____	_____
5. Anger Control Training	_____	_____	_____
6. Relaxation Training	_____	_____	_____
8. Moral Reasoning Training	_____	_____	_____

	Include	Exclude	Additional Service(s)
Other			
1. Clinical Interviews	_____	_____	_____
2. Behavioral Observations	_____	_____	_____
3. Case Management (coordination of services)	_____	_____	_____
4. Research and Evaluation	_____	_____	_____
5. Other (Please Specify): _____	_____	_____	_____

3. In Section II Support Services are organized in three areas. Please review each area and the services provided under each area. Make a recommendation to *include* the specific service or *exclude* the specific service. If you believe that additional services should be included under the area, please suggest the service.

	Include	Exclude	Additional Service(s)
Intervention			
1. Referred to school based intervention team	_____	_____	_____
2. Referred to community based mental health service provider for counseling	_____	_____	_____
3. Referred to school based psychologist for counseling	_____	_____	_____
4. Referred to guidance counselor or social worker for counseling	_____	_____	_____
5. Home-school intervention/collaboration	_____	_____	_____
Assessment			
1. Referred to student services personnel for special education evaluation	_____	_____	_____
2. Referred to student services personnel for a Functional Behavior Assessment	_____	_____	_____

	Include	Exclude	Additional Service(s)
Consultation			
1. Student service personnel assigned as case manager	_____	_____	_____
3. Consultation provided by community mental health provider	_____	_____	_____
4. Consultation provided to classroom teachers	_____	_____	_____

Area

4. How long did it take to complete the entire survey?

_____

5. Are there any recommendations for additional areas or sections in the survey that are currently not present?

_____
_____
_____
_____